Board of County Commissioners

Leon County, Florida

Workshop on Jail Population Management

May 24, 2005
1:30 – 3:30 p.m.

Leon County Board of County Commission Chambers
Leon County Courthouse, 5th Floor

Board of County Commissioners

Workshop Item

Date of Meeting:	May 24, 2005
Date Submitted:	May 18, 2005
To:	Honorable Chairman and Members of the Board
From:	Parwez Alam, County Administrator Vincent Long, Assistant County Administrator Ken Morris, Special Projects Coordinator
Subject:	Workshop on Leon County Jail Issues

Statement of Issue:

To present the Public Safety Coordinating Council's 2004 Annual Report and Recommendations on jail population management, and discuss issues related to the Leon County Jail.

Background:

On May 15, 2001, the Board conducted the Preliminary Action Plan, Jail Population Management Workshop to discuss issues surrounding jail population management with the Sheriff, Public Defender, State Attorney and Judiciary. During this workshop, the Board approved a Jail Population Preliminary Action Plan that included the establishment of the Leon County Public Safety Coordinating Council (PSCC), as outlined in Section 951.26, Florida Statutes.

During a follow-up November 27, 2001 Jail Population Workshop, the Board adopted the Jail Population Management Plan which included an annual report to the Board on jail population each year. This workshop item presents the PSCC's 2004 Annual Report and Recommendations to the Board (Attachment #1).

In addition, during the Board's December 13, 2004 Annual Retreat, the Board made the Leon County Jail Issues one of the top priorities for 2005. This workshop item will discuss the issues raised by the Board during the Annual Retreat and subsequent Board meetings, including:

- Review of Jail's Medical Services Contract
- Review of Jail's Mental Health Services/Protocols
- Evaluation of Jail's Staffing Levels
- Evaluation of Recent Jail Deaths
- Review of Vocational and other Programs available to inmates
- Review of Jail Farm Work Programs
- Review of 1999 Dr. Dina Rose Study, "Drugs, Incarceration and Neighborhood Life: The Impact of Reintegrating Offenders into the Community,"
- Update on Crime Rates in Leon County

Analysis:

2004 Public Safety Coordinating Council Report:

During the November 27, 2001 Jail Population Workshop, the Commission requested that the PSCC deliver an annual report to the Board on jail population. This workshop item presents the PSCC's 2004 Annual Report and recommendation to the Board (Attachment #1). The report addresses:

- The Leon County Jail Population
- Concerns of Mentally Ill Inmates
- The Detention Review Program
- County Probation Programs
- Expansion of Sheriff's Work Camp

To reduce the population burden on the jail while continually monitoring certain nonviolent offenders, the PSCC recommends a pilot project utilizing existing Supervised PreTrial Release (SPTR) Program staff resources and funding from the Leon County Sheriff's Office's (LCSO) Inmate Trust Fund for the lease of alcohol monitoring devices. SCRAM (Secure Continuous Remote Alcohol Monitor) is the industry's first and only continuous, automated, remote alcohol-testing ankle bracelet that automatically tests Driving While Intoxicated (DWI) and other alcohol-fueled offenders at least 24 times a day, regardless of location. SCRAM's technology uses transdermal analysis (through the skin) to determine an offender's Blood Alcohol Content (BAC). Transdermal alcohol testing measures insensible perspiration, which is the constant, unnoticeable excretion of sweat through the skin. This device could reduce the number of nonviolent offenders from being sent to jail while allowing the offenders to maintain normal daily routines such as work and familial responsibilities. The PSCC has invited a representative from Alcohol Monitoring Systems Inc. to demonstrate this technology for the Board at the Jail Population Management Workshop.

Review of Jail's Medical Services Contract:

The LCSO and Prison Health Services, Inc. (PHS) entered into an agreement in October of 2002 for PHS to provide health care services for inmates of the Leon County Jail (Attachment #2). The total contract cost for fiscal year 2004/05 is approximately $3.5 million. Under the agreement, PHS is required to provide medical, mental health, dental, technical, and support personnel as necessary for the rendering of health care services for a population of up to 1,250 inmates. PHS maintains medical records for each inmate that has received health care services from PHS staff. PHS must also submit regular monthly and annual reports to the LCSO relating to services rendered under the agreement that reflect the overall health of the inmates in the jail.

Approximately 90 to 100 inmates visit the clinic each day including the inmates receiving daily medication. According to the agreement between PHS and LCSO, PHS is not responsible for the elective medical care of inmates. Elective medical care is defined as medical care, which, if not provided, would not, in the opinion of PHS' Medical Director, cause the inmate's health to deteriorate or cause definite harm to the inmate's well being.

In addition to providing care for inmates, PHS provides Sheriff's Office staff with annual testing for tuberculosis. Ongoing education programs are also provided at the jail to raise the level of health care awareness for inmates and staff.

Review of Jail's Medical/Mental Health Services/Protocols:

The Leon County Jail is one of 21 county operated correctional facilities in Florida accredited by the National Commission on Correctional Heath Care (NCCHC). NCCHC's mission is to improve the quality of health care in jails and prisons by offering an array of resources to correctional health care facilities. NCCHC's *Standards for Health Services* provides recommendations for managing the delivery of medical and mental health care in correctional systems.

Accredited by the NCCHC in 2003, the Leon County Jail must renew its accreditation every year and pass a site evaluation every three years. NCCHC accreditation benefits LCSO by:

- Promoting and documenting an efficient, well-managed system of health care delivery;
- Improving recruitment efforts;
- Reducing liability premiums;
- Ensuring the health of the public, staff, and inmates through adequate and appropriate health care.

Within the first two hours of arrival at the jail, inmates are given an immediate screening of questions to gather information and identify health concerns. This allows LCSO staff to determine if an inmate needs medical attention or should be placed in a special pod away from the general population. Inmates are required to have a physical before the 14th day of incarceration in accordance with NCCHC guidelines. HIV exams are offered to, but not required, all inmates during the physical. Upon request, inmates are scheduled to see a physician for any reported ailments impairing their health. The clinic staff includes 29.1 FTEs including:

- A part-time psychiatrist
- A dentist that works two days a week
- A full-time medical doctor

Mental Health

In February of 2005, the Florida Legislative Committee on Intergovernmental Relations (LCIR) issued a report on the impact of the mentally ill population on County Jails (Attachment #3). The review identifies the increasing cost of housing and medicating the mentally ill in jails and the appropriateness of their incarceration. The major findings of the review include:

- The resources within the criminal justice system necessary to cope with the mentally ill are inadequate.
- Increases in the costs of anti-psychotic medication and the services provided to mentally ill inmates are shifted to the county.
- Inadequate public funding for community mental health services limits the ability of the criminal justice system to divert the mentally ill from jail to aftercare upon release.

Modeled after the success of the Detention Review Coordinator, the Board of County Commissioners approved the creation of a Court Mental Health Coordinator position within the Court Administrator's Office to improve case processes, information availability, and problem resolution specifically associated with mentally ill defendants. In turn, this information is available to the LCSO and judiciary if a defendant is sentenced to serve time in the jail. The Mental Health Coordinator is committed to making improvements to reduce any delays with cases involving

mentally ill defendants, thus decreasing the cost of caring for this population (Attachment #1). Other efforts to address the mentally ill in the Leon County Jail are reviewed by the Leon County Partners in Crisis Coalition, which is a local coalition of advocates monitoring the growing mental health and substance abuse crisis. Florida Partners in Crisis Inc., began as a statewide initiative in 1999 and continues to work with local jurisdictions on mental health and substance abuse in the criminal justice system.

Evaluation of Jail's Staffing Levels:

In 2004, the average monthly Leon County Jail population reported to the Florida Department of Corrections (DOC) was 1,063 inmates. The Leon County Sheriff's Office (LCSO) uses the DOC's 80% rule for assessing the facility's capacity. Using this guideline, the jail population exceeds the rated capacity when it reaches a population of 975 or more. To operate the jail, LCSO employs 232 sworn personnel. The chart to the right illustrates comparable counties with similar jail populations and the number of sworn correctional officers that work in the jail.

County	2004 Avg. Monthly Population	Sworn Correctional Officers
Manatee	1,027	266
Leon	**1,063**	**232**
Alachua	1,065	175
Pasco	1,067	274
St. Lucie	1,160	193

The number of sworn correctional officers compared to inmates does not properly reflect an accurate ratio of supervision. The structural design of the jail requires that most inmates be grouped together and held in "pods." These pods have a large indoor common area for inmates to gather during the day before resigning to their shared cells at night. The grouping of inmates into the pods is configured by gender, age, mental health, high risk inmates, and administrative discipline. The number of inmates, rules, and authorized interaction of each pod is often determined based on the group of inmates housed in the pod. An adult male general population pod is allowed to mingle in a common area throughout most of the day with scheduled lockdown times to return to their cells. The inmates in the adult male high risk pod are confined to their cells most of the day and are allowed into a common area for a short period of time with very little or no interaction with other inmates. Each pod, regardless of the number of inmates or type of pod, is occupied by one sworn correctional officer at all times. Therefore, one correctional officer may be responsible for up to 94 inmates in Pod K while another correctional officer oversees 28 inmates in Pod H.

LCSO is continuously recruiting for correctional officers. The high stress levels and the long shifts associated with corrections work leave a high turnover rate and constant need for correctional officers in county jails. While the statistics vary, the comparable counties contacted to gather population and staffing data expressed similar challenges with recruiting and retaining correctional officers. In an effort to determine the competitiveness of LCSO compensation as compared to like-sized and local organizations, the Office of Management and Budget conducted a compensation study at the Board's request. On February 22, 2005, the Board accepted the recommendations to implement a three year average annual salary increase for LCSO staff. The recommendation included an average salary increase of 5.8% over a three year period, beginning in 2006, for sworn

corrections staff. The Board's action will solidify the competitive salaries of correctional officers compared to similar sized counties once the increases take effect.

Evaluation of Recent Jail Deaths:
This item is a late attachment report of the three most recent jail death investigations (Attachment #4).

Review of Vocational and other Programs available to inmates:
Approximately 700 inmates participated in the vocational, educational, and substance abuse programs offered by the Leon County Sheriff's Office in 2004. General Education Diploma (GED) classes, mentoring seminars, alcoholics anonymous, and narcotics anonymous programs are regularly offered throughout the week, including evenings, to rehabilitate inmates and provide them with the proper tools to reintegrate with society. Additional programs include a literary program, bookmobile visits, HIV awareness and prevention, and an attitude and behavior class (Attachment #5).

During the 2004 school year, which runs from August of 2003 to May of 2004, 197 inmates were enrolled in GED classes. Of the 51 inmates that took the GED Test in 2004, 23 (45.1%) passed the test and the remaining 28 (54.9%) inmates partially passed the test by earning satisfactory scores on three or more sections of the examination. One hundred percent of the juveniles that took the GED Test and the FCAT passed (Attachment #6).

Review of Jail Farm Work Programs:
During the FY01/02 budget process, the Board funded eight new correctional officer positions in the LCSO budget to allow for expansion of the weekend work camp to a seven day operation. The work camp averaged 40 people each day in 2004 and provided inmate labor assistance to organizations such as Habitat for Humanity, Mother's In Crisis, Leon County Schools, City of Tallahassee Parks and Recreations, Mosquito Control, Leon County Heath Department, and Leon County Public Works. The expansion of this program has allowed more offenders to serve their sentence through the weekly work program while remaining in their jobs, with their families, and in their communities (Attachment #1). On February 8, 2005, staff was requested to bring back a report on jail farm work programs in other areas of the state, which uses labor from committed offenders rather than offenders who serve in the weekly work program as an alternative to jail time. Staff interviewed representatives from three Florida County Sheriff's Offices, and the following is a summary of each of these programs.

Marion County
Since the year 2002, the Marion County Sheriff's Office (MCSO) has been operating a Jail Farm Work Program. The impetus behind the program was the Sheriff's assumption that inmates would most likely fair better in society, and not return to jail, if a work ethic was instilled while serving time in the jail. Thoughts turned to the jail's food budget, and the idea of running a farm from inmate labor to supplement food that was purchased for the jail was born.

MCSO entered into a lease agreement for land with the Department of Environmental Protection, Office of Greenways and Trails for a nominal cost to start their farm. The inmates cleared the land by

hand, using hand tools, and began actually farming the land in 2002. The Program uses approximately 100 inmate laborers a day for the operation of the farm. Operations include planting seeds in a greenhouse, transplanting seedlings to the field, cultivating cuttings into plants, oversight of an ornamental garden, maintenance and construction of all necessary building structures, grounds keeping, harvesting, and oversight of 4,500 chickens, 25 pigs, and a herd of cattle. All of the produce grown on the farm is used in the jail kitchen. The chickens produce all of the eggs needed in the jail kitchen (approximately 100,000 a year), and the pigs and cattle are used to supplement some of the meats consumed in the jail.

In addition, the MCSO has a partnership with the University of Florida (UF) whereby inmate labor is used by the UF Plant and Science Research Unit for planting and harvesting of the various crops they grow. Produce grown by the UF Plant and Science Research Unit is also given to the jail to supplement the food needed to feed inmates.

The inmates are also given educational opportunities while working on the farm. There is a school house on site, and classes in horticulture, ornamentals, and general nursery management are given to the inmates to help them run the farm. They are also provided the opportunity to take classes toward earning their GED.

MCSO estimates that the jail farm work program provides a $300,000 reduction in their jail food budget each year. The estimated cost to operate the program in 2004 was $126,000. The majority of this cost is the staffing of Correctional Offices to oversee the farm inmates and instructors to educate them. Staffing for the 100 daily inmates breaks down to: two Correctional Officers, one Sergeant, one civilian farm manager, one civilian correctional assistant, and two instructors.

Generally, only non-violent sentenced or un-sentenced misdemeanants are allowed to work on the farm. Inmate farm laborers are afforded up to nine days per month off of their sentences for time worked on the farm. The MCSO Jail Farm Work Program is in addition to other various work programs available in the county (e.g., road clean-up crews).

Pasco County

The Pasco County Sheriff's Office (PCSO) operates not only a jail farm, but also a hydroponics unit and a fish farm. All produce and fish harvested are used to supplement the jail's food supply. The PCSO started their farm operation on three and one half acres of Board property. (The Fish Farm is a converted retention pond on the jail property). Start-up costs were covered by use of the inmate welfare fund, as well as available grant funds. The cost to operate the farm programs is an estimated $250,000 a year. This amount funds the staffing of the operation by two deputies.

The Program "employs" three to 15 inmate laborers each day. The inmates are typically sentenced, non-violent misdemeanants (e.g., DUIs, drug offenders). PCSO also contracts with the South West Florida Water Management District for the use of six inmate laborers to remove exotic plants in local water bodies. The Farm Program is in addition to other various work programs available in the county (e.g., road clean-up crews). PCSO has plans to expand their Farm Program to include hogs and cattle in the near future.

Monroe County

Monroe County Sheriff's Office (MCSO) operates a petting zoo with the use of inmate labor. The zoo, called the "Children's Animal Park" is located on about two acres of the MCSO detention center grounds. The park was started in 1994 as a haven for homeless animals and has grown into a park, complete with aviary, reptile exhibit, rabbit warren, farm animals and other domestic and exotic species.

> "Animals at the park are cared for primarily by Detention Center inmates, who also benefit from the experience. They receive formal training in some aspects of animal husbandry which they may be able to use once they are released from the facility. At the very least, they learn to work closely with many creatures in need of the compassion and caring of a human being - an experience which cannot help but be a positive factor in their lives."

Two to four inmates are used to operate the park each day through the care of the animals or upkeep of the landscaping. There are strict criteria for the type of inmate who qualifies for work on the park - typically, misdemeanant drug offenders are selected to work the program. The park also benefits from the volunteering of a local veterinarian who tends to the animals' medical needs.

The cost to operate the park is approximately $20,000 a year (does not include salary expenses). The purpose of the park is to find the animals homes within the community.

The examples above are just a few of the types of jail farm models that are operated in Florida. Evident in staff's discussions with representatives of the above programs, the major factors to be considered when pursuing a farm program are: 1) land on which to operate the farm, and 2) staffing of correctional officers or other relevant staff to oversee the inmate labor. Both of these factors could have significant financial impacts, particularly in the start-up years of the operation.

Review of 1999 Dr. Dina Rose Study, "Drugs, Incarceration and Neighborhood Life: The Impact of Reintegrating Offenders into the Community":

Dr. Dina Rose, a professor at John Jay College of Criminal Justice, City University of New York, and two colleagues, conducted a study on Frenchtown and South City in 1999 to investigate the aggregate impact of incarceration on the quality of community life in areas experiencing high levels of incarceration. The community impacts analyzed in the report are the problems of stigma upon incarceration; the financial impact of incarceration on individuals, families, and neighborhoods; and, the interpersonal dynamics of community relationships and networks (Attachment #7).

Dr. Rose presented the results of her research regarding the impact of incarceration on the community at the October 31, 2000, Leon County Jail Population Workshop. The research report included numerous recommendations such as:

- Target families of incarcerated offenders for an array of services such as short-term financial assistance for food, clothing, and housing;
- Facilitate contact between families and incarcerated individuals;
- Provide transitional housing for offenders upon release;

- Assist ex-offenders in obtaining and retaining employment; and,
- Make training, education, and legal assistance available to ex-offenders.

Subsequent to the Jail Population Workshop, on November 14, 2000, the Board directed staff to review electronic monitoring, look at process improvements to reduce waiting time for arraignments, and bring an action plan to review the feasibility of implementing alternative programs discussed at the October 31, 2000, Leon County Jail Population Workshop. The alternative programs included:

- A review of the various work programs currently in place;
- Request the Criminal Justice Coordinating Council to provide guidance on the appropriate size of the jail and when it needs to be expanded;
- A review of the requirements for housing juveniles;
- A review of state funding levels for mental health services; and,
- A review of programs designed to reduce recidivism as recommended in Dr. Rose's research.

On May 15, 2001, the Board conducted the Preliminary Action Plan, Jail Population Management Workshop to further discuss issues surrounding jail population management and involved the Sheriff, Public Defender, State Attorney, and Judiciary in the discussion and approval of the Preliminary Action Plan.

Preliminary Action Plan
1. Direct staff to work with the CJCC, and to utilize the CJCC to perform the responsibilities outline in Florida Statutes, Section 951.26, Public Safety Coordinating Council (to formulate recommendations to ensure that the detention center's capacity is not exceeded, including the assessment of related programs, and to project future capacity needs).
2. Direct staff to identify a representative from the local Big Bend Workforce Development program and from the Refuge House, and request the CJCC Chairperson to appoint these representatives to 4-year terms.
3. Request CJCC to bring back recommendation to the Board in six months on increased coordination activities or new programs to reduce jail population.
4. Request Sheriff to bring back to the Board recommendations and potential jail population reductions within his authority to reduce jail population (not including jail expansion).
5. Bring back for Board consideration during FY 2001-2002 budget workshops the creation of a full-time position to carry-out responsibilities associated with the jail population management system project.
6. Direct staff to research alternatives to pay for the conversion of the drill academy to Unit 5 of the jail, as a minimum security /work release facility (to be brought back during the November 2001 workshop).
7. Authorize the appointment of a citizen task force to study the issue of over-representation of minorities in the jail.
8. Direct staff to bring back the issue of incarceration of the mentally ill in an upcoming agenda item to establish the Board's legislative priorities for the 2002 legislative session.
9. Authorize the re-establishment of the "pity committee" as recommended in the Public Defender's April 5, 2001 letter to the Board Chairman.
10. Schedule a workshop for November 2001 to review information requested and actions taken on the Preliminary Action Plan.

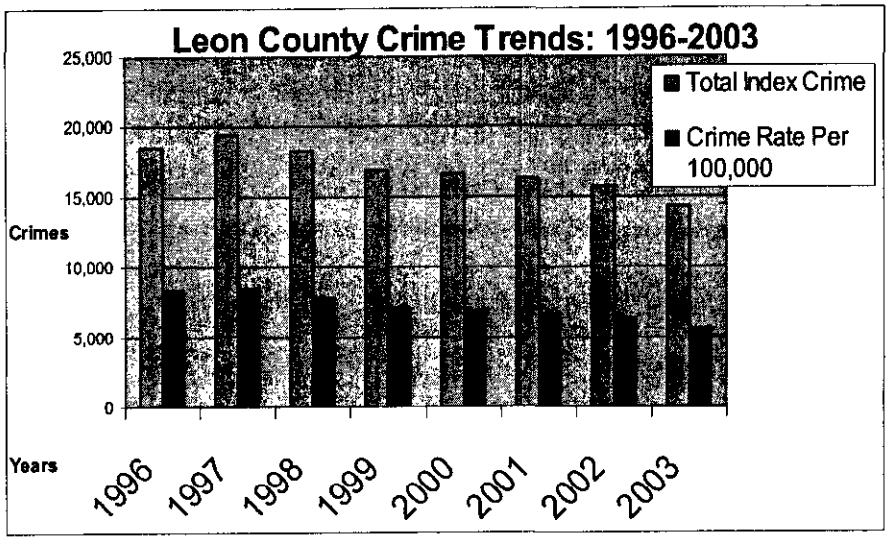
On December 11, 2001, the Board ratified the actions taken at the Jail Population Management Workshop from November 27, 2001:

- The Board formally requested that the PSCC deliver an annual report to the Board by the end of each calendar year on jail population.
- The Board encouraged the use of electronic monitoring and GPS monitoring as a jail alternative for post-conviction sentencing, where appropriate.
- The Board requested that individuals released from jail by the efforts of the Detention Review Coordinator or other bond review initiatives be tracked for recidivism.
- The Board encouraged the PSCC Chairperson to include members of the community to the PSCC, including representatives from the Community Justice Center and representatives from local workforce and training centers.
- The Board requested that the PSCC include in their next report recommendations for crime prevention programs and initiatives.

The PSCC submits its annual report to the Board for consideration during the jail workshop. Each item that was ratified by the Board on December 11, 2001 is addressed in the PSCC Annual Report.

Update on Crime Rates in Leon County:

Staff retrieved crime trend data from the Florida Department of Law Enforcement (FDLE) to identify the long term crime trend in Leon County. Between 1996 and 2003, Leon County has experienced a steady increase in population and a corresponding decrease in the total crime index and crime rate per 100,000 residents. Despite a brief peak in 1997, the crime rate per 100,000 residents has decreased from 8,374.21 in 1996 to 5,607.83 in 2003 in Leon County (Attachment #8). FDLE reports that the statewide average crime rate per 100,000 residents in 2003 was 5,164.2.



At the Board's request, LCSO provided geographic information on the number of arresting charges made by LCSO in the County by patrol zone (Attachment #9). LCSO currently divides its patrol operations into eight zones, two of which encompass the City of Tallahassee. Zones 7 and 8, which are the two patrol zones in the City, had significantly more arrest charges in 2004 than the patrol zones in the rural areas of the County. Please note that arresting charges will differ from Uniform Crime Report (UCR) data because UCR only captures certain charges. Also, the attached figures represent arrest charges. Therefore, one individual that is arrested could have multiple charges.

The Tallahassee Police Department (TPD) also provided a map of its eight patrol areas in the City accompanied with 2004 arrest information by each area (Attachment #10).

Review of Tallahassee Police Department's Arrest Procedures:

Since TPD makes the majority of arrests in Leon County, the Board requested staff to conduct a brief review of TPD's arrest procedures. TPD provided staff with its General Orders Manual, which outlines the Department's policy, procedures, guidelines, and statutory authority for making arrests (Attachment #11).

The General Orders Manual outlines officers' responsibilities and duties to uphold the laws of Florida and ensure citizens rights mandated by the U.S. Constitution. More specifically, the arrest procedures of TPD are left to the discretion of its officers. Different procedures are required of on-duty police officers versus off-duty police officers. On-duty police officers must use "reasonable judgment and appropriate discretion to take all steps necessary to affect an arrest of a suspect" believed to have violated a law or ordinance. When making an arrest, officers are prohibited from considering a victim's willingness to pursue criminal charges in court or the possibility of the suspect being prosecuted.

The Manual also describes situations where circumstances might cause officers to not make an arrest. For example, if an arrest would cause a greater risk of harm to the general public than not arresting the suspect or if police resources are limited and there are a large volume of high priority calls, officers are advised not to make the arrest. Officers may obtain and execute arrest warrants for suspects that they have probable cause to believe committed a crime after the officer is removed from the situation that led to the decision not to arrest a suspect.

Review of Tallahassee Police Department's Community Capacity Development Program:

The Community Capacity Development Office, formerly known as the Executive Office for Weed and Seed, implements a strategy designed by the U.S. Department of Justice's Office of Justice Programs that incorporates community-based initiatives. It is a comprehensive multi-agency approach to law enforcement, crime prevention, and community revitalization. Operation Weed and Seed is a strategy which aims to prevent, control, and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhoods across the country. Nationwide, Weed and Seed sites range in size from several neighborhood blocks to 15 square miles.

Operation Weed and Seed is foremost a strategy--rather than a grant program-- which aims to prevent, control, and reduce violent crime, drug abuse, and gang activity in targeted high-crime neighborhoods across the country.

The strategy involves a two-pronged approach: law enforcement agencies and prosecutors cooperate in "weeding out" criminals who participate in violent crime and drug abuse, attempting to prevent their return to the targeted area; and "seeding" brings human services to the area, encompassing prevention, intervention, treatment, and neighborhood revitalization.

A community-orientated policing component bridges weeding and seeding strategies. Officers obtain

helpful information from area residents for weeding efforts while they aid residents in obtaining information about community revitalization and seeding resources.

In FY 04/05, Tallahassee Police Department received a $217,037 grant from the Department of Justice for this program. It provides funding to "weed out" the criminal element in the following targeted areas: Richmond Heights, Murat Hills and South City (Attachment #12). The program also offers a comprehensive range of human service programs to stimulate revitalization in the designated areas. Specifically, in the Tallahassee/Leon County area, the grant funds three safe houses, one Program Coordinator Position, and overtime for law enforcement.

Partnerships with other law enforcement agencies and community organizations help promote weeding and seeding activities that focus on educational, recreational, social, and economic development. These include such groups as the Police Athletic League (PAL); About Face; Becoming A Man (BAM); Parks and Recreation; Leon County Shared Services; and Mothers In Crisis. Law enforcement partners include the U.S. Attorney; State Attorney; Leon County Sheriff's Department; Department of Corrections; Parole and Probation; Juvenile Justice; Drug Enforcement Agency; and Alcohol, Tobacco and Firearms.

Conclusions:

Since the 2001 Jail Population Management Workshop and the adoption of the Preliminary Action Plan, the Board has taken significant and proactive steps to manage and reduce the population of the Leon County Jail. The creation of the Court Mental Health Coordinator has assisted both the judiciary and LCSO in assessing the competence of offenders and identifying mental health concerns. The Detention Review Coordinator, also funded by the Board, facilitates speedy identification, processing and case management of jailed defendants. The Board has also increased funding for the LCSO work camp to allow nonviolent offenders to work in the community rather than serve time in the jail. Board approval to expand the Global Positioning Satellite Program (G.P.S.)/ CrimeTrax funding to purchase additional tracking devices has proven to be a cost effective tool commonly used by the judiciary in circumstances whereby jail time is not necessary (Attachment #1). As mentioned previously, the Board approved a salary increase for all LCSO sworn employees, including corrections staff, to improve recruitment of correctional officers and adjust salaries to the competitive market.

In an effort to reduce the number of alcohol-fueled offenders in the jail, the PSCC 2004 Annual Report recommends the implementation of a pilot program using an alcohol monitoring system. The SCRAM device is an ankle bracelet that can measure a person's alcohol intake up to two times an hour. The proposed pilot project would utilize existing SPTR Program staff resources and funding from the LCSO Inmate Trust Fund for the lease of the alcohol monitoring devices. SPTR would oversee the three month pilot project period beginning October 1, 2005, with the lease of five SCRAM units. Depending upon the success of the first three months, as well as resource availabilities and impacts, the pilot project period may be extended an additional three months. Hours of operation to hook-up or remove the devices are recommended between 8:30 a.m. - 3:30 p.m., during normal County business days. Training of local staff and SCRAM device monitoring during the pilot project period would be provided by AMS.

Options:

1. Accept the PSCC 2004 Annual Report and Recommendations.
2. Do not Accept the PSCC 2004 Annual Report and Recommendations.
3. Board Direction.

Recommendation:

Option #1

Attachments:

1. PSCC 2004 Annual Report
2. Agreement between LCSO and Prison Health Services, Inc.
3. 2005 Florida Legislative Committee on Intergovernmental Relations Report on the Impact of the Mentally Ill Population on County Jails
4. Jail Deaths Report
5. LCSO programs offered to Leon County inmates
6. 2004 GED statistics from the Leon County Jail
7. 1999 Dr. Dina Rose Study, "Drugs, Incarceration and Neighborhood Life: The Impact of Reintegrating Offenders into the Community"
8. Leon County Crime Trends: 1996-2003
9. 2004 LCSO Arresting Charges by Patrol Zone
10. 2004 TPD Arrests by Patrol Area
11. TPD General Orders Manual
12. Community Capacity Development Office service area

PUBLIC SAFETY COORDINATING COUNCIL

2004 ANNUAL REPORT

Submitted May 24, 2005

Public Safety Coordinating Council
2004 Annual Report
Executive Summary

The Public Safety Coordinating Council (PSCC) was established in Leon County in the summer of 2001. The Council has met regularly since that time to monitor the jail's population as well as increase efforts of coordination between the many agencies of the criminal justice system, and recommend continuation of existing programs, or establishment of new programs that may aid in the alleviation of jail crowding, pursuant to Section 951.26, Florida Statutes.

The report that follows presents an overview of the jail population in relation to previous years and the County's general population. The report presents population data including charges, average lengths of stay in the criminal justice system, as well as race, sex and age. This data is compared to similar information reported in 2000 through 2003 as well as Leon County general population statistics.

The average daily inmate population of the Leon County jail has increased by 4.3% from 2003 to 2004 compared to the Florida Department of Corrections, which saw an increase of 5.1% in inmate population. The PSCC 2004 Annual Report uses a snapshot of statistical data from the county jail by providing an array of information from November 23, 2004. This specific day was chosen to be consistent with the previous annual report to illustrate the demographics of the jail population, the presence of violators of probation, the number of drug offenders incarcerated, and other pertinent information for the PSCC.

Over the past few years, the jail's population has been nearing full capacity on a regular basis. The Leon County Sheriff's Office uses the Department of Correction's 80% rule for assessing the facility's capacity. Using this guideline, the jail population exceeds the rated capacity when it reaches a population of 975 or more. Over the past year, the PSCC has met to review each jail alternative program to identify if programs are being fully utilized and what enhancements could be made to reduce the overcrowding burden in the jail.

The 2004 Annual Report recommends a pilot program under the Leon County Supervised PreTrial Release (SPTR) Program to monitor alcohol-related offenders using a device that can measure a person's blood alcohol level 24 hours a day. The SCRAM (Secure Continuous Remote Alcohol Monitor) device enables a supervising authority of alcohol-related offenders to have access to reliable test results while using minimal staff time.

The PSCC will continue to meet to review the jail population, improve upon criminal justice agency coordination, and review alternative programs that help alleviate jail crowding while keeping the community safety and health of its citizens as the primary responsibility and goal of the Council.

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I. PUBLIC SAFETY COORDINATING COUNCIL

During the Board of County Commissioner's May 15, 2001 Jail Population Workshop, the Board voted to establish a Public Safety Coordinating Council (PSCC) whose purpose is to meet periodically and make recommendations of new or existing programs or system enhancements that would help effectively monitor and manage the County Jail population. The PSCC, by statute, is comprised of the following individuals, or their representatives: the State Attorney; the Public Defender, the Chief Circuit Judge, the Chief County Judge, the Sheriff, the State Probation Administrator, the Chairman of the County Commission, the County Probation Director, the Director of a local substance abuse treatment program, and representatives from county and state jobs programs and other community groups who work with offenders and victims.

The Statutory Responsibility of PSCC's, per Section 951.26, Florida Statutes is as follows:

> (2) The council shall meet at the call of the chairperson for the purpose of assessing the population status of all detention or correctional facilities owned or contracted by the county, or the county consortium, and formulating recommendations to ensure that the capacities of such facilities are not exceeded. Such recommendations shall include an assessment of the availability of pretrial intervention or probation programs, work-release programs, substance abuse programs, gain-time schedules, applicable bail bond schedules, and the confinement status of the inmates housed within each facility owned or contracted by the county, or the county consortium.

Charge of the PSCC by Board of County Commissioners

During the May 15, 2001 Workshop, the Board indicated that they would like Leon County's PSCC to formulate recommendations to ensure that the detention center's capacity is not exceeded, including the assessment of related programs, and to project future capacity needs. An additional charge of the PSCC is to meet regularly and make recommendations of new or existing programs or system enhancements that would help effectively monitor and manage the County Jail population.

Additionally, during the February 26, 2002 regular meeting, the Board conveyed the following:

> "It would be appropriate for the PSCC to oversee and monitor the effectiveness of the increased use of tracking technology, and the coordinated assessment and case management of probationers as proposed in this item. The deployment of the tracking devices will be determined by the protocol developed by Court Administration and approved by the PSCC. It is also suggested that the PSCC include a City of Tallahassee representative."

> "It is also recommended that the PSCC convene with the specific purpose of meeting with the Citizens Task Force on Over-Representation of Minorities in the Leon County Jail (Citizens Task Force). Both the PSCC and the Citizens Task Force have developed recommendations to address jail population issues that have been submitted to the Board in the past. Together, the PSCC and the Citizens'Task

Force can develop a common action plan to be submitted to the Board of County Commissioners."

Current membership of the Leon County PSCC consists of the following individuals or their designees:

- State Attorney (does not participate in meetings)
- Public Defender
- Chief Circuit Judge
- Chief County Judge
- Chief Correctional Officer (Sheriff)
- State Probation Circuit Administrator
- Chairperson of the Board of County Commissioners (Currently Chairperson of PSCC)
- County Probation Director
- Chief of Police, Tallahassee Police Department
- Director of a Local Substance Abuse Treatment Program
- Representative from County and State Jobs Programs
- Representative from Community Group that works with Victims
- Representatives from the Citizens' Task Force on the Over-Representation of Black Youth and Adults in the Jail (Added on May 7, 2002)
- Representative from the Leon County Community Justice Center, Inc. (Added on May 7, 2002)

The following pages constitute the PSCC's 2004 Annual Report to the Board. The report presents the current status of the Leon County jail population including the demography of jail inmates, as well other incarceration alternatives and programs that are currently in use in Leon County.

II. LEON COUNTY JAIL POPULATION

The following information is provided to present an update on the current jail population and relevant population trends over the past few years. It is important to note that the general population of Leon County has grown from 239,452 in the year 2000 to 263,896 in 2004 (10.2%). With this in mind, it is evident that the jail population has remained only slightly elevated despite the trend of healthy increases in the county's overall population from year to year.

In comparison, the Florida Department of Corrections reports in their 2003-2004 Annual Report that inmate populations in Florida's prisons have reached 82,000, which is an increase of 15.5% since 2000 and a 6.0% increase in the last fiscal year (July 2003 through June 2004). The majority of inmates in state prison on June 30, 2004 are male (93.5%) and black (51.9%). However, the percentage of black inmates in prison is decreasing (58.0% in June 1994 to 51.9% in June 2004.)

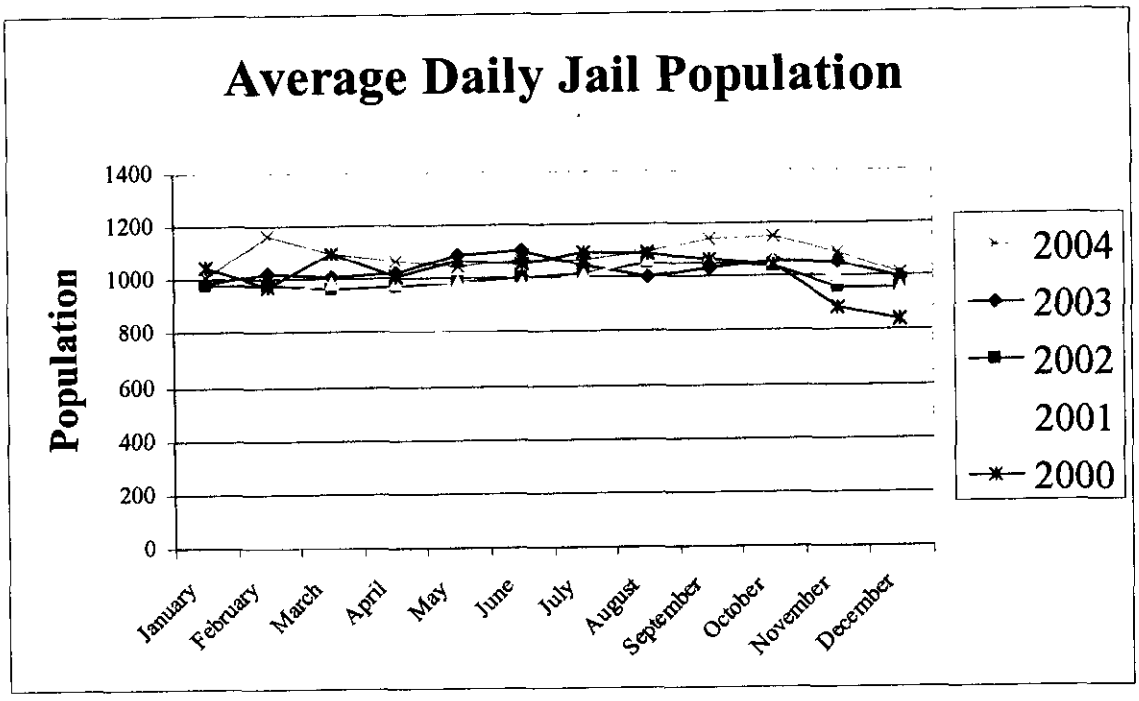
Average Daily Jail Population

The following data illustrates the average daily jail population over the past three years:

Month	2000	2001	2002	2003	2004
January	1050	904	978	984	1009
February	971	943	980	1021	1167
March	1098	984	966	1013	1097
April	1010	991	975	1027	1067
May	1068	988	990	1087	1045
June	1052	979	1004	1106	1067

Month	2000	2001	2002	2003	2004
July	1097	1008	1019	1047	1066
August	1087	1065	1055	999	1095
September	1071	1075	1057	1028	1141
October	1050	1062	1040	1059	1153
November	881	994	959	1054	1089
December	843	957	956	993	1012

Annual Average:	2000	2001	2002	2003	2004
	1023	996	998	1039	1084



Demography of Jail Inmates

A snapshot of the November 23, 2004 jail population resulted in the following race, sex and age breakdown of the inmates:

Age Group	White Males	Black Males	Other Males	White Females	Black Females	Other Females	Total by Age Group
Juvenile	1	4	0	0	0	0	5
18- 29	96	323	1	17	53	0	490
30-39	68	190	1	15	34	1	309
40-49	62	108	1	13	22	1	207
50-59	21	35	0	2	3	0	61
Over 59	5	6	0	0	0	0	11
Total	253	666	3	47	112	2	1083
% of Total	**23.4%**	**61.5%**	**0.3%**	**4.3%**	**10.3%**	**0.2%**	**100%**

In comparison, the following is a breakdown of Leon County's general population by sex and race taken from 2000 census data (percentages of total population):

Female - 52.3%
Males - 47.7%

White (including Hispanic) - 66.4%
Black or African American - 29.1%
Other - 4.5%

Violators of Probation (VOPs)

The presence of Violators of Probation (VOPs) is also a contributing factor in jail crowding. VOPs are often "technical" in nature for violations such as failure to pay probation costs, or failure to regularly report to a probation officer one's address and phone number but can also include leaving the state having never reported to the probation office, continuing to use drugs, as well as contacting a victim. It is important to note that on November 23, 2004 the jail had the following breakdown of VOP detainees whose violations were pending in court:

194 Adult Male Felony Probation Violators
52 Adult Male Misdemeanor Probation Violators
46 Female Felony Probation Violators
14 Female Misdemeanor Probation Violators

On the above date, VOPs comprised 28.3% (306 offenders) of the jail's overall population. The Courts continue to review pending VOP cases to address this population of the jail.

Arrest Data by Agency

The Florida Department of Law Enforcement (FDLE) reports 5,134 arrests in Leon County between January and June of 2004. Of those arrests, 28.8% were made by the Leon County Sheriff's Office and 59.9% were made by the Tallahassee Police Department (Attachment A).

Top Five Crimes/ Arrest Data

The following tables present the top five felony and misdemeanor arrests made in calendar year 2004.

Top 5 Felony Arrests - Calendar Year 2004

Rank	Description of Felony	Number of Arrests
1	GRAND THEFT IS $300 OR MORE BUT LESS THAN $5000 (F.S. 812.014 2C1)	1447
2	DRUGS-POSSESS CONTROLLED SUBSTANCE WITHOUT PRESCRIPTION (F.S. 893.13 6A)	762
3	HALLUCINOGEN-MFG SCHEDULE II (F.S. 893.13 1A1)	432
4	PASS FORGED ALTERED INSTRUMENT (F.S. 831.02)	378
5	VEHICLE GRAND THEFT-3RD DEGREE	318

Top 5 Misdemeanor Arrests - Calendar Year 2004

Rank	Description of Misdemeanor	Number of Arrests
1	TRAFFIC OFFENSE DUI ALCOHOL OR DRUGS 1ST OFF (F.S. 316.193 2A)	928
2	NONMOVING TRAFFIC VIOL DRIVE WHILE LIC SUSP 1ST OFF (F.S. 322.34 2A)	832
3	BATTERY TOUCH OR STRIKE (F.S. 784.03 1A1)	716
4	MARIJUANA-POSSESS NOT MORE THAN 20 GRAMS (F.S. 893.13 6B)	715
5	NARCOTIC EQUIP-POSSESS AND OR USE (F.S. 893.147 1)	619

The majority of defendants arrested solely for nonviolent misdemeanor charges are released on their own recognizance, pretrial released, or post a nominal bond and are released from custody fairly quickly. These lower-level charges generally do not significantly impact the jail population, but do represent a high number of arrests locally.

A snapshot of the jail's population on November 23, 2004 reveals that the adult and juvenile population was comprised of offenders of the following crimes. (For the purposes of this report, in those cases in which multiple crimes were committed by an offender, the offender is categorized by the most severe of his/her crimes):

Jail Population on November 23, 2004

ADULTS:

Felony Offenses	Total Offenders
Other Personal/ Violent Crimes	222
Drugs	219
Theft Fraud	196
Burglary	88
Robbery	66
Other Felony	39
Sex Offense	38
Murder	33
Other Property	11
Bad Check	0
Misdemeanors	
Bad Check	1
Traffic	38
Non Check	106
Civil	2
Holds	19
Total	**1078**

JUVENILES:

Felony Offenses	Total Offenders
Robbery	2
Sex Offense	1
Other Personal/ Violent Crimes	1
Drugs	1
Other Felony	0
Burglary	0
Misdemeanors	0
Total	**5**

Drug Offenders

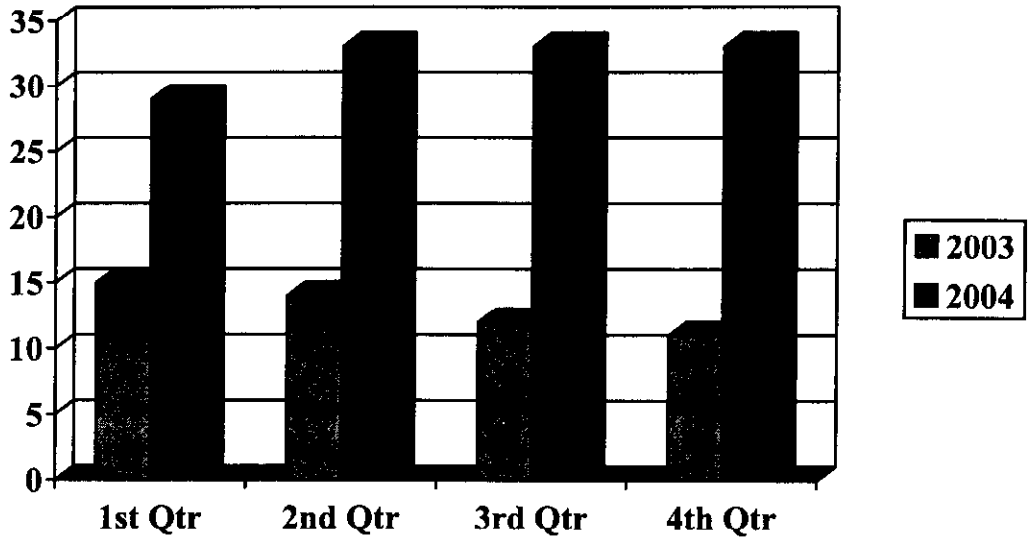
On November 23, 2004, it was reported that 219 of the inmates in the jail were incarcerated (sentenced or awaiting disposition) for drug offenses. This number accounted for 20.3% of the total jail population that day.

While these numbers represent a significant part of the jail population, there is a large population of inmates that have been charged with other crimes that are caused by substance abuse. There is a strong correlation between substance abuse and domestic abuse, burglary and other crimes that are committed to obtain drugs or while under the influence of drugs or alcohol. Many are also repeat offenders that serve their time and then re-enter the community without the necessary skills or support to escape from their addiction.

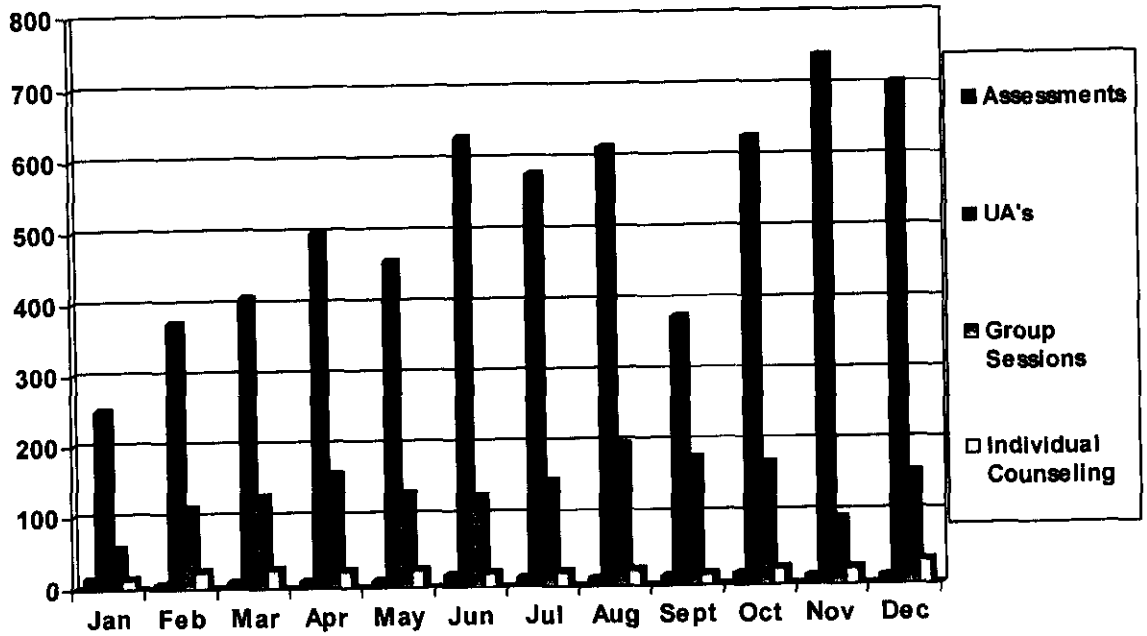
Drug Court

The Leon County Felony Drug Court is a pretrial intervention program for persons with no prior felony convictions and charged with a second or third degree felony for the purchase or possession of a controlled substance. Candidates must not have any pending felony cases or be on active Department of Corrections supervision. Participants accepted to the program are required to complete a minimum twelve-month, three-phase substance abuse treatment program. Phase I requires weekly or biweekly reporting to Drug Court with a minimum of two urinalysis tests per week. Phase II requires bimonthly reporting to Drug Court with either a weekly or biweekly urinalysis testing. Phase III requires random urinalysis testing and reporting to Drug Court on a quarterly basis. The frequency of supervision and treatment intensity declines as participants move to the next phase. Charges are dismissed if the participant successfully completes the pretrial intervention program. Persons not successfully completing the program are prosecuted through the normal judicial process.

In 2004, 128 defendants were admitted to the program and 33 defendants graduated during the calendar year. The calendar year of 2004 Drug Court has more than doubled the number of



clients admitted to the program compared to the calendar year of 2003.If these 128 drug court defendants received the customary criminal court sentence of 2 years probation and 30 days in jail, initial jail bed costs would have exceeded $249,000.00. Additionally, the traditional sanction avoided the inevitable secondary costs of jail incarceration due to violations of probation. Drug Court clients are not subjected to the secondary or subsequent costs of jail incarceration due to actual successful drug treatment intensive services, with approximately 75% graduating successfully between twelve to eighteen months.



Moreover, defendants who receive the intensified services and monitoring of the Drug Court are much less likely to re-offend in the community. Of the 95 defendants who participated in Drug Court in 2002, only 14 were arrested within the following year, and overall total drug court clients have a less than 10% rate of recidivism. Nationally, the average recidivism rate for drug court clients is 16.5% within one year. This low recidivism rate is unparalleled when compared to the traditional criminal court sanctions.

Average Length of Stay for Various Offenses

The following data was compiled from snapshots of the jail population on November 25, 2003 and November 23, 2004 and depicts the number of days that inmates were held in jail between arrest and arraignment and arraignment and trial:

Inmates Awaiting Arraignment

Days between Arrest and Arraignment	11/25/2003 (# of inmates)	11/23/2004 (# of inmates)	Difference (# of inmates)
1 - 30 Days	490	670	180
31 - 60 Days	33	42	9
61 - 90 Days	4	2	-2
91 - 210 Days	1	9	8
Over 210 Days	0	8	8

Inmates Awaiting Trial

Days between Arraignment and Trial	11/25/2003 (# of inmates)	11/23/2004 (# of inmates)	Difference (# of inmates)
1 - 30 Days	10	13	3
31 - 60 Days	88	14	-74
61 - 90 Days	173	208	35
91 - 210 Days	97	394	297
Over 210 Days	82	102	20

The PSCC continues to collaborate to decrease the lengths of stay, when possible through coordination of the criminal justice offices, of individuals assigned to the jail. Of the 744 jailed defendants with court matters pending on February 2, 2004, 305 (41%) were released from custody or had all pending court matters disposed by March 1, 2004. The average length of stay until disposition or release was 64 days.

III. Mentally Ill

Deinstitutionalization of the mentally ill and their resultant involvement in the criminal justice system has added an additional burden to the jail and the criminal justice system. While in jail and on medication, the inmates are deemed to be safe to return to society. However, when many are discharged, they go off their medication and often return to the criminal justice system.

During the FY 2003/2004 budget process the Board approved the creation of a Court Mental Health Coordinator position within the Court Administrator's Office. This position is modeled after the success of the Detention Review Coordinator, and is focused on improving case processes, information availability, and problem resolution specifically associated with mentally ill defendants. The Court Mental Health Coordinator's primary focus thus far has been to identify areas in the criminal justice process where improvements can be made to decrease any and/or all delays with cases involving mentally ill defendants, thus decreasing the cost of caring for this population. Critical areas include:

- Crisis Intervention Training (CIT)
- Mentally Ill Misdemeanants
- Identification of Mentally Ill Defendants
- Competency Process
- Future Goals

Crisis Intervention Training (CIT)

The Court Mental Health Coordinator, along with Chris Summers of Tallahassee Police Department (TPD), Lynne Hernandez, and National Association of the Mentally Ill (NAMI) Tallahassee conducted the first Crisis Intervention Training (CIT) in Tallahassee from December 6th - 10th, 2004. Crisis Intervention Training is designed to enhance communication between law

enforcement officers and the mentally ill they encounter. All speakers for the training are local experts and/or professionals who have volunteered their time to do training. Training requires forty hours of study covering topics such as signs and symptoms of mental illness, risk assessment, the Baker and Marchman Acts, the dually diagnosed, child and adolescent mental health issues, geriatric issues, and other disorders that mimic mental illness. The initial class of trainees had a total of twenty-six (26) officers. Participating officers included TPD, Capital Police, and Florida Agricultural & Mechanical University Police (FAMU). This program will be conducted at least three times per year and will hopefully include officers from all law enforcement agencies in Tallahassee and the surrounding area. The next training is tentatively set for the month of April, 2005.

Mentally Ill Misdemeanants

The Court Mental Health Coordinator also examined the occurrences of mentally ill defendants repeated arrests for misdemeanors. The most effective course of action thus far with these cases has been to have a Judge order the defendant to one of the receiving facilities in Leon County for assessment and stabilization if the defendant meets Baker Act criteria. This allows the individual to be treated at a psychiatric facility instead of the jail. The hope here is to work with the attorneys to dispose of the case before the defendant is discharged from the receiving facility, thus eliminating the need for the individual being transported back to the jail. If a case is not disposed of prior to the individual being stabilized, the Court has the option of placing the defendant on pretrial release with mental health conditions, to release the defendant on his/her own recognizance, to impose a bond, or to have the defendant return to the jail.

Identification of Mentally Ill Defendants

The third responsibility the Mental Health Coordinator is the proper and timely identification of defendants with a mental illness. This has proven to be difficult as some inmates enter the jail and never identify themselves as mentally ill until they have been there for some time or their behavior prompts attention. One of the major issues deals with that of confidentiality. It is often difficult to obtain complete information about an individual's mental health history without their consent. Thus, weekly meetings with the Court Mental Health Coordinator, Prison Health Services jail staff, and Department of Children & Families (DCF) personnel have been established to help ensure no one falls through the cracks. Also, the Mental Health Coordinator established a biweekly forensic screening meeting where Apalachee's Forensic team meets with the Mental Health Coordinator and attorneys to staff cases involving mentally ill defendants in an effort to dispose of cases as soon as possible.

Competency Process

When examining the process of evaluating a defendant for competency to stand trial, a few areas were immediately identified where significant delays have been occurring. One such area was the time it took appointed experts to evaluate a defendant and file the evaluation with the court. In some cases, hearings were postponed because the Court was still awaiting the results from competency evaluations. With each delay, mentally ill defendants were forced to stay in jail for a longer period of time. The reasons for this delay included;

- The expert not receiving the order of appointment and thus not knowing the defendant needed evaluating,
- Experts having too many evaluations to do in too short of a time, and
- Upon initial evaluation, experts found the case needed more attention and would take a longer time to complete.

To help remedy this problem, the Mental Health Coordinator sought to establish relationships with the experts that were being appointed for competency and sanity evaluations. Through this effort, these experts can now notify the Mental Health Coordinator when they are unable to complete an evaluation in a timely manner. When the Court is notified in advance of a delay, the hearing can be rescheduled based upon the date the expert says the evaluation can be completed in order to eliminate any unnecessary hearings. There is also the option for the expert to report when they feel another expert should be appointed due to time constraints. A database of when evaluations are ordered, which experts are being appointed, and how long it takes them to complete evaluations has been established. This database allows for follow up with experts to help ensure that they have received the order and will be filing it on time. Please note that when confidential competency or sanity evaluations are ordered, evaluations are a bit harder to track as the evaluation may not be talked about until the actual competency hearing.

Another area in the competency process where many delays were occurring was the delivery of the admission packet to the Department of Children and Families (DCF) and/or the time it takes DCF to actually admit a defendant to one of their treatment programs. DCF does not put a defendant on their forensic waiting list until a complete packet has been received by the designated person at their headquarters. After being placed on the waiting list, Florida Statutes mandate an admission within fifteen (15) working days. The delays were occurring because in many instances, even though the Court had mailed a packet, DCF somehow never received it, or if the packet was received, it was found to be deficient of one or more documents and thus the defendant would not be placed on the waiting list until the packet was complete. (In most cases the defendant is not transported within the fifteen day period. The average amount of days for a DCF admission is roughly twenty-three (23) days. A more accurate analysis will be available in a later report).

Future Goals

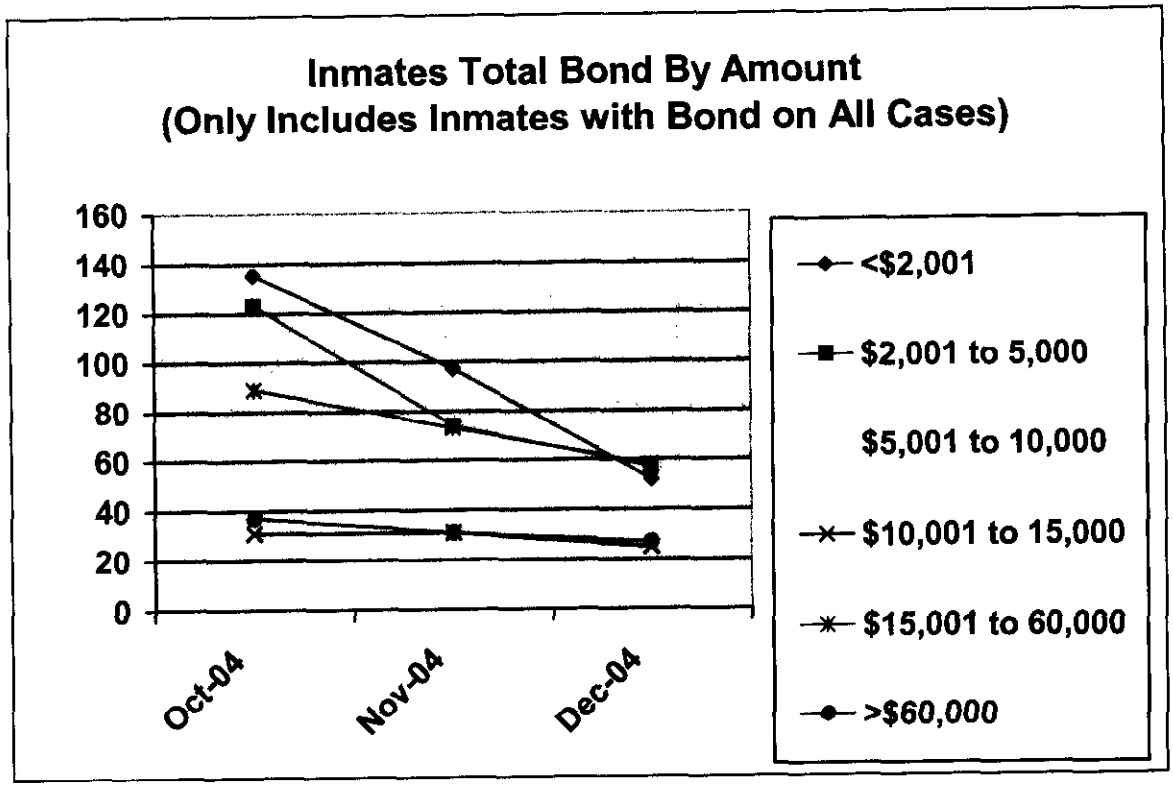
The Court Mental Health Coordinator is currently working on compiling statistical data from databases established on mentally ill defendants. This data will be presented in a formal report from the Detention Review Unit in the near future.

Also, over the course of the next year, it is the goal of the Court Mental Health Coordinator to work with many agencies to establish a comprehensive jail diversion program in Leon County. As it stands, Leon County currently has many components/programs essential for a jail diversion program, but there is not a comprehensive system pulling all of these components together. The goal is to not only have all of these components working together, but to also add more programs and create a diversion program tailor made for Leon County.

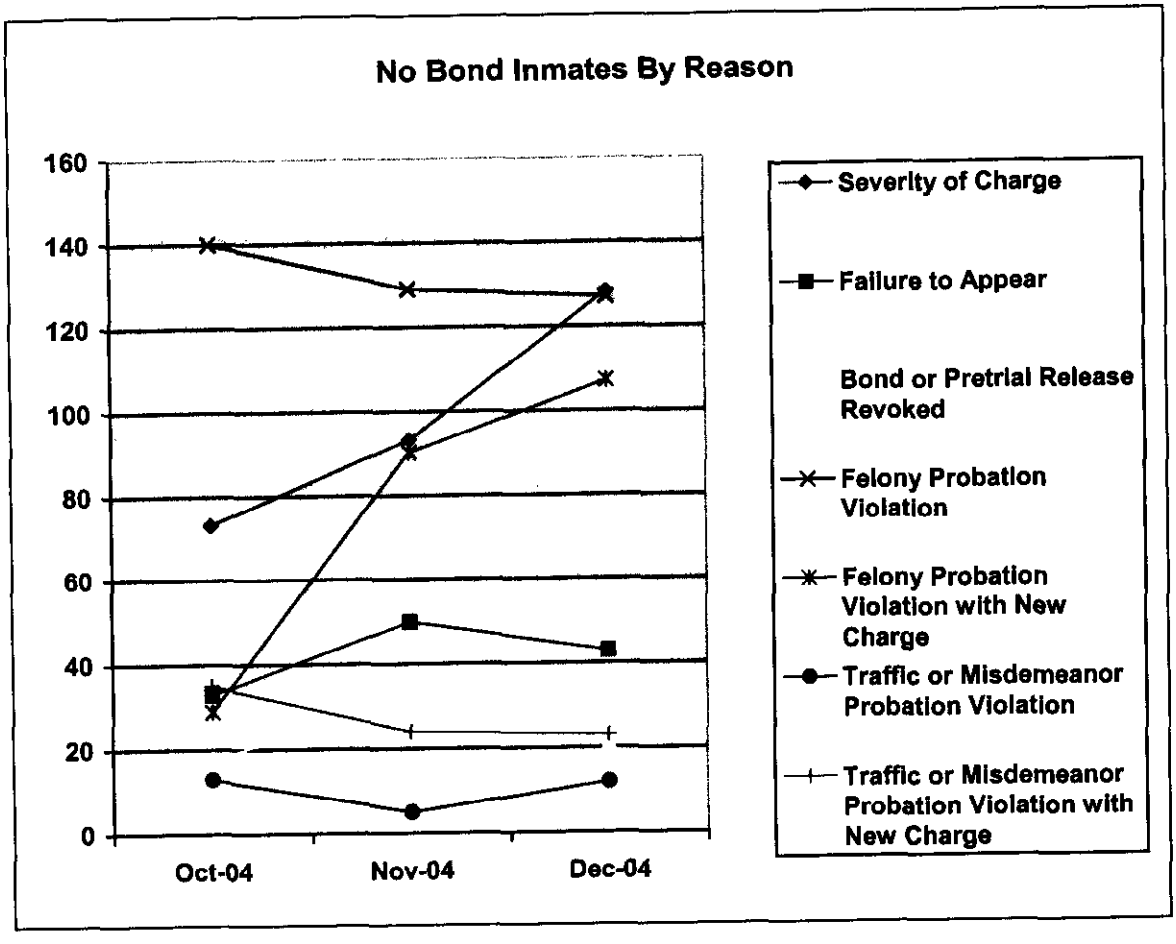
IV. DETENTION REVIEW PROGRAM

On November 26, 2001, a Detention Review Coordinator was hired under the Office of Court Administration. The current Detention Review Coordinator has been with the unit since August of 2004 and continues to facilitate speedy identification, processing and case management of jailed criminal defendants. Weekly lists of jailed misdemeanor and traffic defendants are prepared manually and provided to the judges and attorneys for expedited review and disposition of cases. Recently, a biweekly list of felony technical probation violators and a weekly list of misdemeanor and traffic technical probation violators has been maintained and provided to judges and attorneys for easy identification and review. The traffic docket is reviewed each Monday to identify and avoid capiases being issued for jailed defendants.

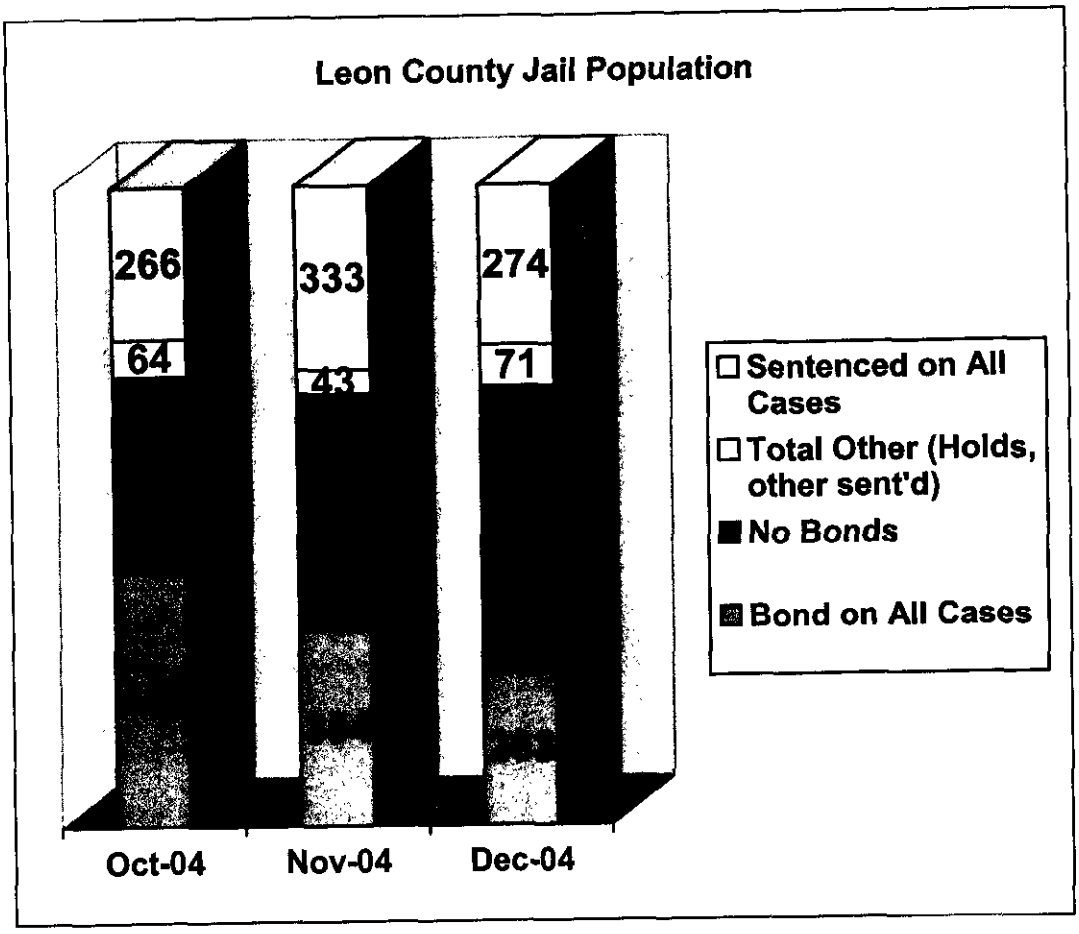
The chart below provides information on the total bonds set on pretrial detainees and was compiled on the first business day of the month.



The line graph below shows pretrial detainees without a bond and reason for which they do not have a bond. The reason is by order: Felony Violation of Probation With or Without New Charges, Misdemeanor/ Traffic Violation of Probation With or Without New Charges, Bonds or Pretrial Release Revoked, Failure to Appear. Where multiple reasons for no bond exist the person is only counted once by the above methodology. Severity of charge is only used when no other reason is applicable.



The following chart classifies the total jail population by defendant status. "Other" defendants include those held for other counties, who are pretrial and sentenced, and those held on writs or for child support. The bottom portion includes those defendants who could be released on bond but either do not have the means to pay the bond or choose not to post bond for release.



In the upcoming year, the Detention Review Coordinator is planning to address issues relating to duplicate Special Persons Number (SPN), create a spreadsheet to monitor jail population changes on a daily basis, and create a new jail alternative packet to include mental health and substance abuse treatment facilities in conjunction with the Mental Health coordinator.

V. COUNTY PROBATION PROGRAMS

The Leon County Probation Division is in its final year (2001-2005) of funding from the Byrne Memorial Grant which enhanced several alternative programs for the Court's use in disposing of cases. Funding was used to expand the use of offender/probationer monitoring through the addition of Passive GPS technology and the Enhanced Probation Program (EPP). The following sections provide an update on the various monitoring programs offered by the County Probation Division and Probation Work Program.

Enhanced Probation Program (EPP):
Probationers sentenced to EPP are provided more intense supervision with required weekly reporting to a Case Management Coordinator (grant funded position). Prior to enrollment in the program, a comprehensive risk/needs assessment is completed to determine appropriateness. If acceptable, a coordinated case management plan is created for this specialized caseload of high risk probationers. There is limited funding available for counseling, treatment and drug testing if the client demonstrates a need for financial assistance. Clients in the program are required to pay the monthly supervision fee of $50 for the services provided. Placement in the program is a court-ordered condition of probation. The average monthly caseload count for the Program has been approximately ten clients.

Global Positioning Satellite Program (G.P.S.)/ CrimeTrax
The GPS Program continues to serve as a viable alternative sanction to the Judiciary, in specifically identified court cases. Fiscal year 2003/2004 funding for the tracking devices (both "passive" and "active") was provided by the Leon County Sheriff's Inmate Trust Fund. Total cost for the leasing of the units was $81,133.00. Approximately $40,581.00 collected in fees from the defendants in the program was transferred to that account to defray leasing cost.

Although clients are required to pay a portion of the costs ($5.00 daily) for the devices, approximately 21 clients were assigned to the program with fees waivers during FY 2003/2004. The length of stay in the program for pretrial defendants varies from the date of release from custody/enrollment, to disposition and in probation cases by the length of the probationary period.

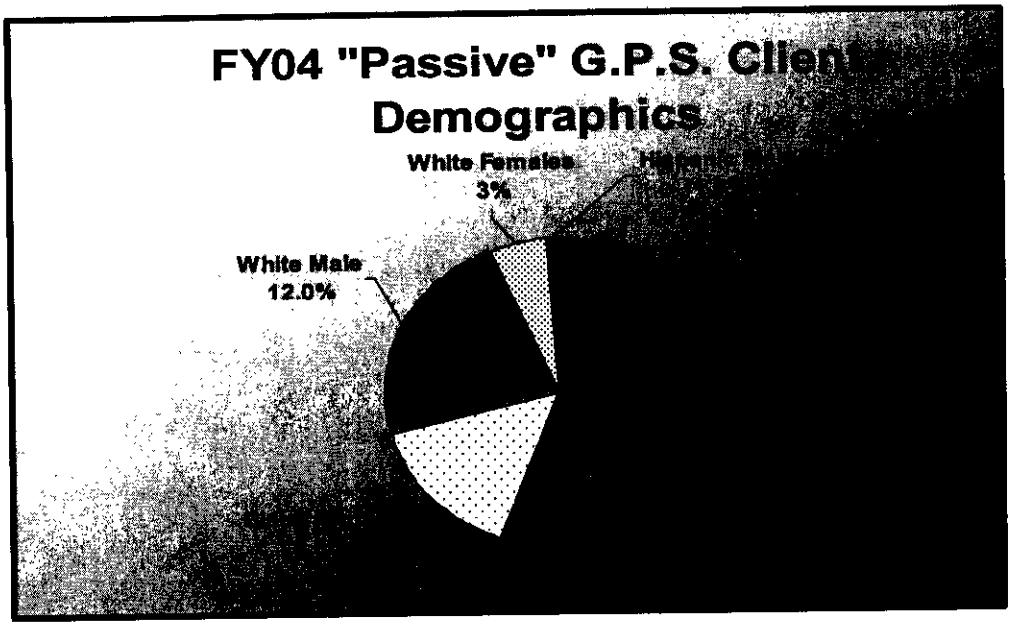
The location information of offenders on both "Active" and "Passive" GPS Monitoring is linked to the Florida CrimeTrax system. Using this system, probation officers and local law enforcement agencies are automatically notified if a tracked probationer was near a reported crime when it occurred. In addition, accurate and reliable GPS tracking of probationers is determined to have a significant impact on public safety by changing criminal behavior through the awareness that they are being constantly monitored.

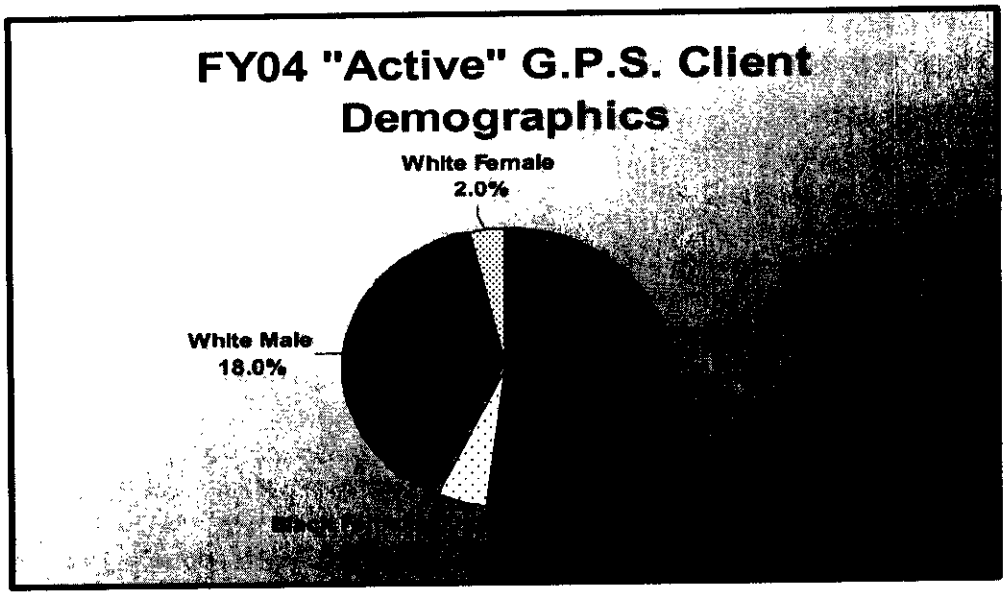
"Active" G.P.S. provides around the clock real time tracking and notification of offender violation of court imposed location restrictions. Two (2) PreTrial Release Specialists are available 24 hours a day to respond immediately to offender violations. "Active" G.P.S. units are recommended for use in those cases involving a victim (i.e. Sexual Battery, Stalking, Domestic Violence, or Assault).

"Passive" G.P.S. also provides 24 hour tracking of defendant movement. However, the information is stored and provided to the assigned Pre-Trial Release Specialist the following day. Staff reviews the defendant's violation reports at least once daily and initiates follow-up contact with the defendant as needed. Passive G.P.S. devices are recommended for non-victim offenses (i.e. property offenses, defendants who fail to report to appointments, chronic trespass, failures to appear, etc.).

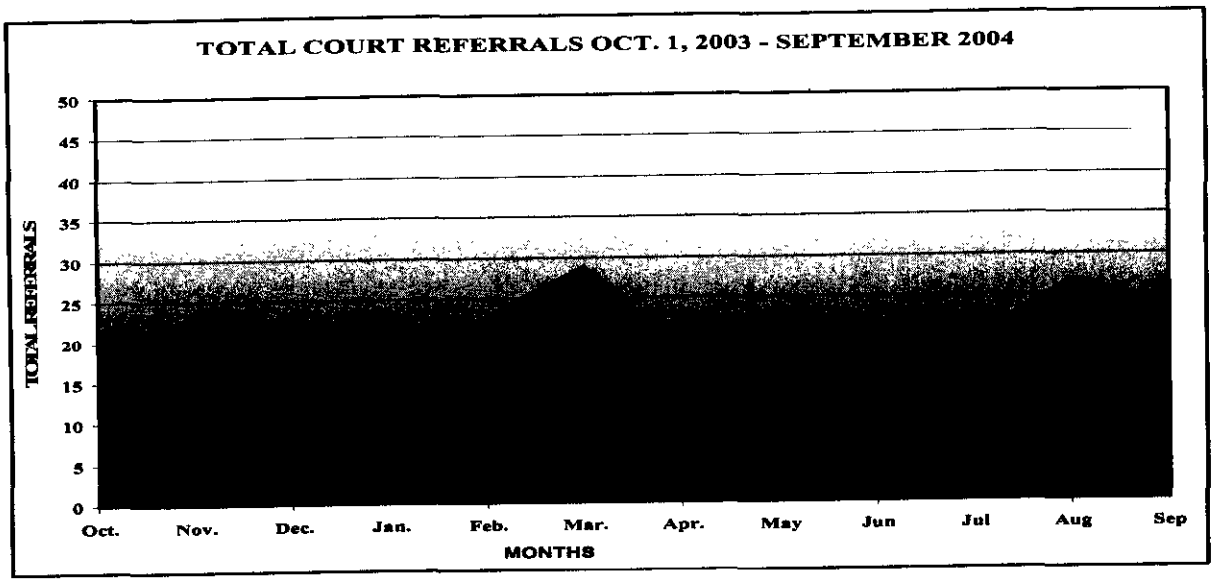
In FY 2003/2004 a total of 260 defendants were referred for "active" or "passive" G.P.S monitoring. Of the 260 defendants referred, 160 were released for supervision,

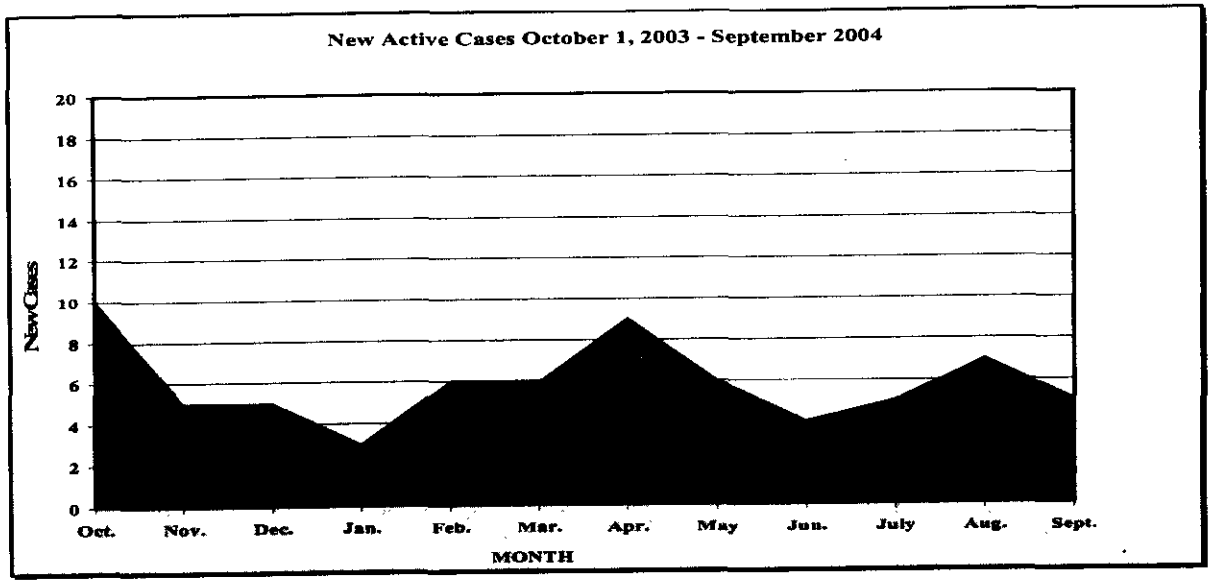
- 71 were assigned to "active" units:
  - 66 (or 92.9%) were on Supervised PreTrial Release(SPTR) and
  - 5 (or 7.1%) were under probation supervision.
- 89 defendants were assigned "passive" units and all were with the SPTR program.



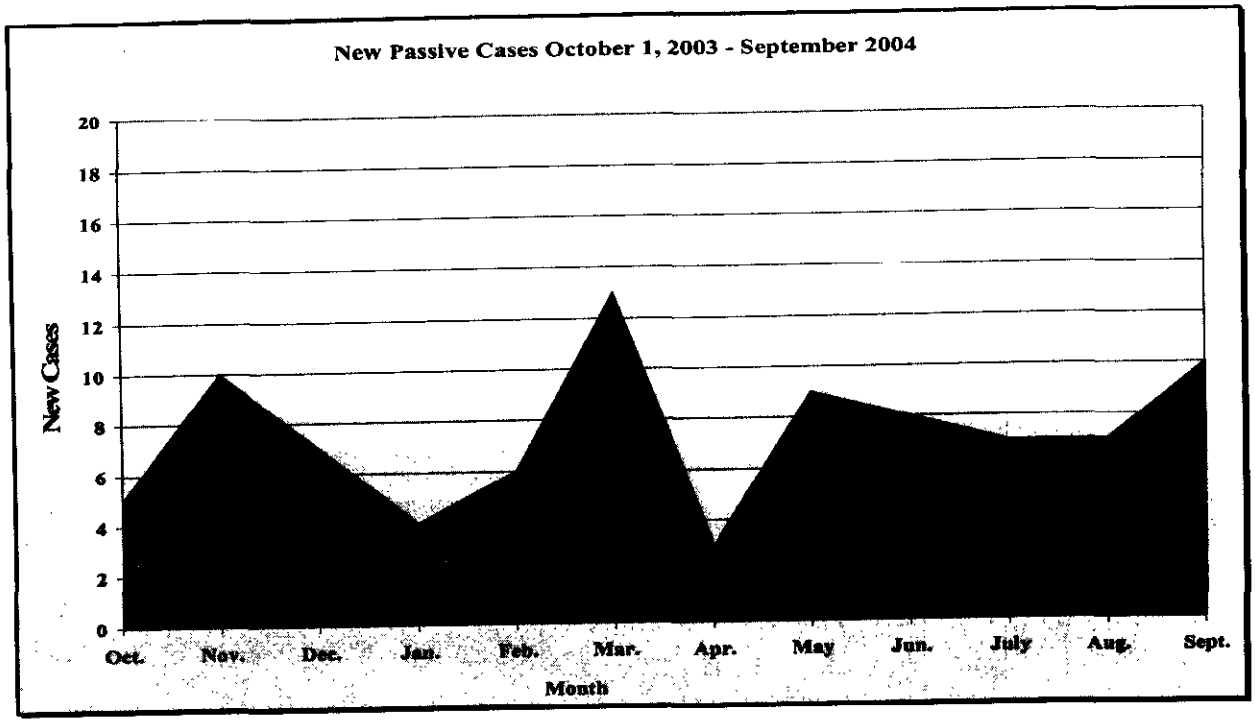


In 2003/2004 assignments for "Passive" G.P.S. monitoring were added to the caseload. During this period, clients assigned for tracking increased 29%. The graphs below reflect the total number of court ordered referrals for GPS monitoring each month and the number of new assignments made each month by unit type. "Active" cases per month are as follows: (Oct-10, Nov -5, Dec -5, Jan-3, Feb-6, Mar-6, Apr-9, May-6, Jun-4, Jul-5, Aug-7, Sept-5)





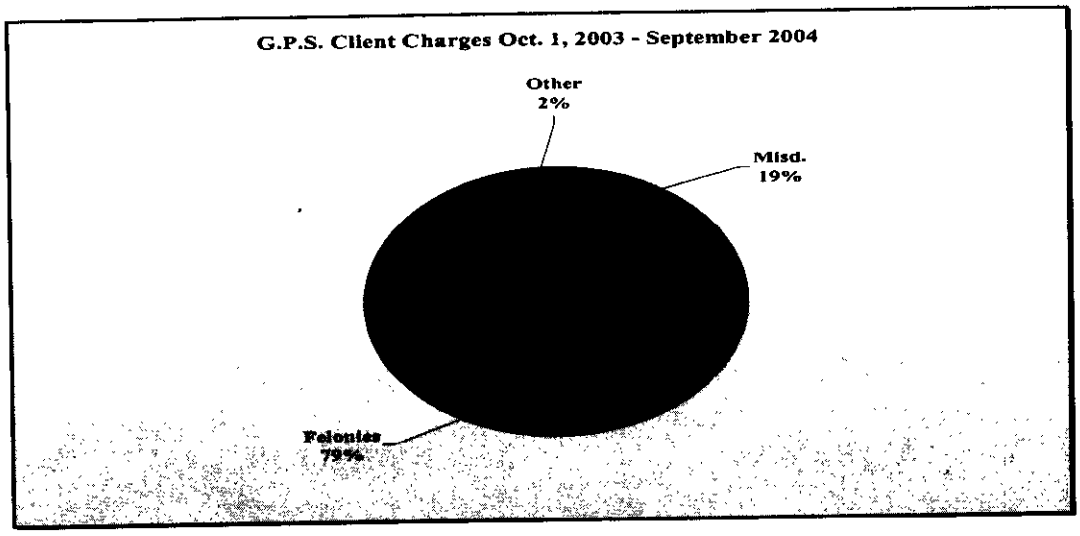
The number of "Passive" cases per month are as follows: (Oct-5, Nov-10, Dec-7, Jan-4, Feb-6, Mar-13, Apr-3, May-9, Jun-8, Jul-7, Aug-7, and Sept.-10)



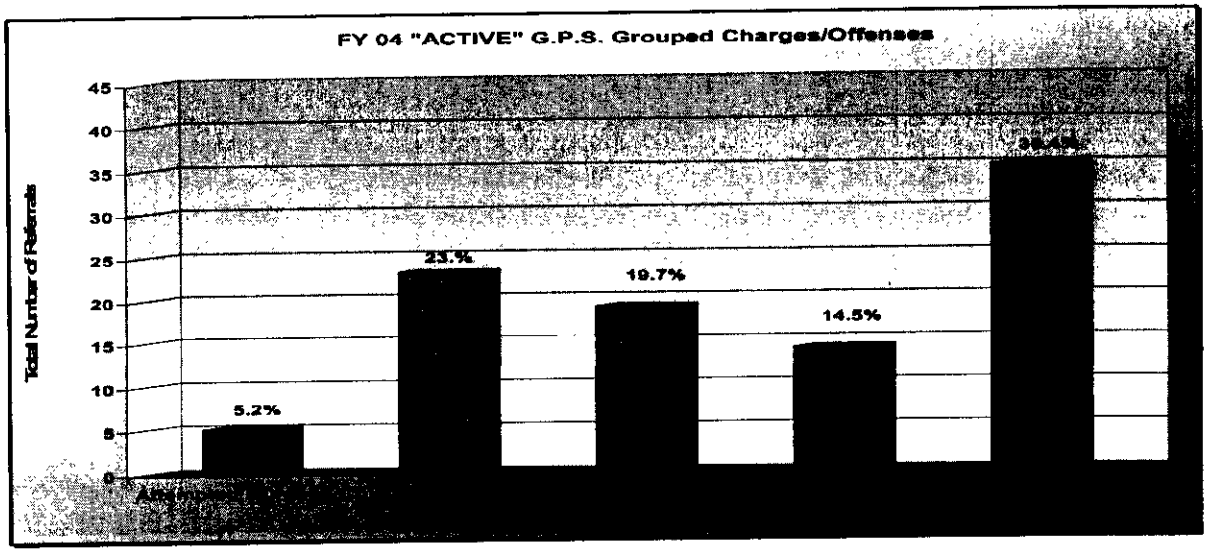
Staff monitored an average of 43 "Active" and "Passive" GPS cases a month. The following table details average monthly caseload gains and losses.

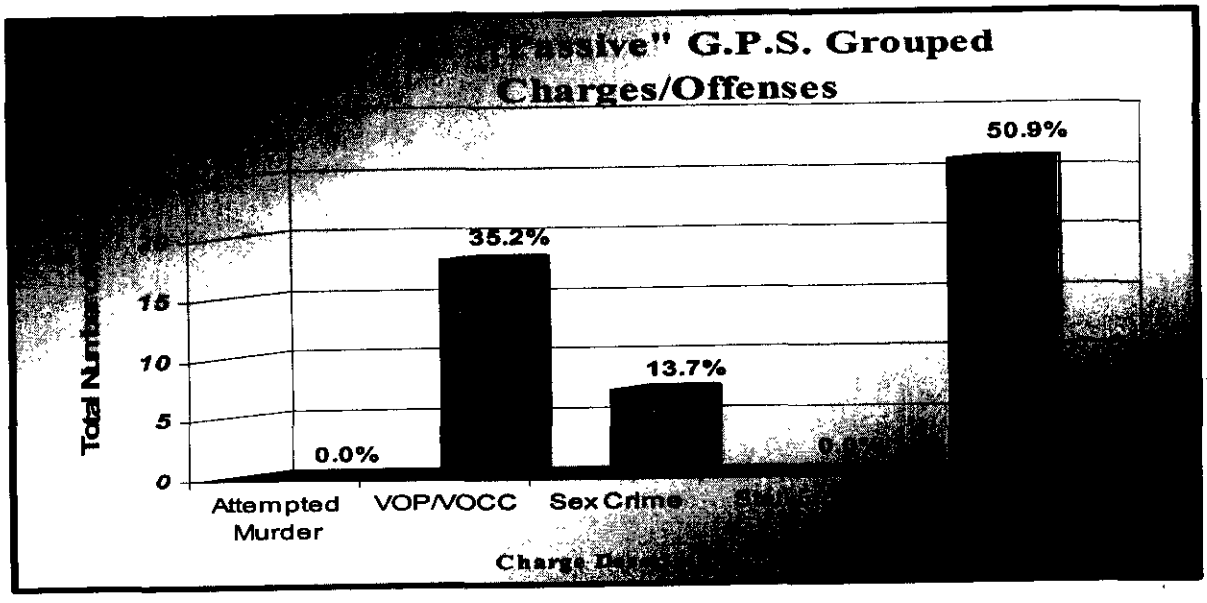
CASELOAD SUMMARY	
Average # Cases Carried Over From Previous Month	38
Average # New Cases/Month	+15
	53
Average # Cases Closed/Month	-10
Average # Cases/Month	43

"Active" G.P.S. clients' charges were largely felonies (79%) versus misdemeanors (19.0%). Though specific charges varied widely, the types of charges were often similar. A chart depicting these general types of charges follows:



Many clients had more than one charge or offense. Certain charges appeared frequently. The following alternate grouping of charges looks at cases involving battery, including felony battery, domestic battery, aggravated battery and aggravated assault, stalking, to include stalking, aggravated stalking, and stalking to harass, sex crimes, such as sexual battery, sexual assault, and capital sexual battery, violation of probation (VOP) or community control (VOCC) and/or attempted murder. This review reflects both "active" and "passive" G.P.S. referrals.





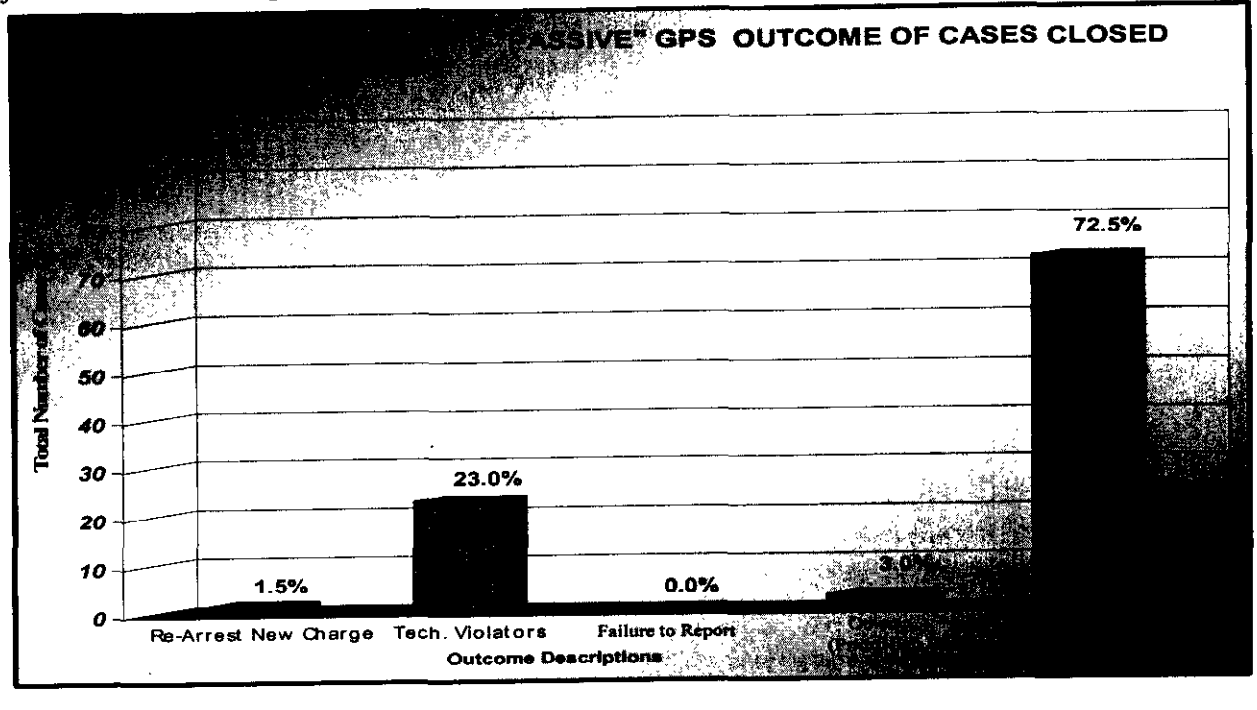
The county would have spent approximately $597,360 (12,445 days of supervision at $48.00/day) in fiscal year 2003/2004 to provide jail space for "active" and "passive" G.P.S. clients. In addition, clients were able and required to maintain and/or gain employment, care for dependents, if any, and pay for their own physical and medical care. A table estimating the alternative cost of jail follows. NOTE: Cost savings to the jail is used for comparison purposes only. The jail only realizes true cost savings when pods of the jail can be closed.

COST TO JAIL FY04 ACTIVE and Passive GPS CLIENTS		
Total # Supervision Days	**(X) Estimated Cost/Day of Jail**	**(=) Total Cost**
12,445	$48	$597,360
# Supervision Days/Client	**(X) Estimated Cost/Day of Jail**	**(=) Cost/Client**
77.8	$48	$3,734.40

A fund was established by the Board of County Commissioners, which is used to pay for the cost of G.P.S. supervision for indigent clients. The daily fee of $5.00 per unit was waived for those defendants found to be legally indigent by a judge. The following table details the use of the Indigence Fund account created by the Board of County Commissioners for fiscal year 2003/2004. Three clients with on-going fee waivers were carried over to fiscal year 2004/2005.

Total	1444	$7,220

By the end of the fiscal year, 124 cases closed with 90 or 72.5% completing successfully. Of the remaining 27%, 34 can be categorized as unsuccessful completions. Three types of unsuccessful cases are depicted in the following chart: 1) those arrested on new charges (2) or 1.5%, 2) technical violators who violated other conditions of supervision such as remaining drug free or not having contact with victims, and 3) a single violation for failure to report to the pretrial office as instructed in court. (4) or (3.2%) defendants, labeled other below, were never released from jail because of other prior pending charges and/or a hold from another county.



The monthly caseload average for the G.P.S. program was 43. Estimated cost savings to the County at the rate of $48.00 per day in jail was $597,360. NOTE: Cost savings to the jail is used

for comparison purposes only. The jail only realizes true cost savings when pods of the jail can be closed.

As of September 30, 2004, there were no county probation cases assigned GPS monitoring.

Electronic Monitoring - Telephone Based

This system uses a tracking device that is connected electronically through the telephone of an offender, resulting in a "house arrest". The person wears an ankle transmitter that sends a signal to a field monitoring device (FMD) that is plugged into the person's phone. The FMD will call the host computer randomly every few hours to report that the device is within range and report in immediately if the offender moves out of range. A schedule is developed for the offender by the appropriate probation officer that will allow the person to go shopping for groceries, attend church, etc. Proof of these activities is required such as receipts from the grocery or church bulletins. The weakness of this system is that when the offender is away from the house, their actual whereabouts are unknown and verified at a later date.

This system can be used for both felonies and misdemeanors although there is some case law that questions the legality of using these devices for misdemeanors. There is a $5.00 a day charge to the offender but there is also an indigent account, funded by the County, which would pay for this service if the offender was unable to. During this fiscal year these devices were seldom used by the Court.

Alcohol Monitoring Systems, Inc

The PSCC invited a representative from Alcohol Monitoring Systems, Inc. (AMS) to the April 5, 2005 regular meeting to present information on a device that can monitor a person's alcohol intake 24 hours a day. According to the business proposal presented by AMS, **SCRAM** (Secure **C**ontinuous **R**emote **A**lcohol **M**onitor) is the industry's first and only continuous, automated, remote alcohol-testing ankle bracelet that automatically tests Driving While Intoxicated (DWI) and other alcohol-fueled offenders at least 24 times a day, regardless of location. SCRAM's technology uses transdermal analysis (through the skin) to determine an offender's Blood Alcohol Content (BAC). Transdermal alcohol testing measures insensible perspiration (which is the constant, unnoticeable excretion of sweat through the skin). The average person will emit approximately one liter of insensible perspiration each day.

Designed specifically for application in long-term monitoring programs where alcohol abstinence is required, SCRAM delivers fact-based, around the clock snapshots of an offender's alcohol consumption to the supervising authority. With SCRAM, the court systems have an unprecedented level of continuous offender accountability and access to reliable tests results, so offender intervention can occur quickly and efficiently. SCRAM's continuous–testing protocol allows for testing and reporting schedules unique to each offender, for the same fee, and can provide testing for up to 48 times per day. Unaware of when BAC readings are taken, the offender can maintain normal daily routines such as work, counseling, and familial responsibilities instead of traveling to testing centers. Lastly, SCRAM'S patented tamper

resistant ankle bracelet automatically alerts the supervising authority of any tampering or interference between an offender's skin and the device to ensure accurate readings.

The SCRAM System consists of three (3) integrated components:

1.) An 8 oz. Bracelet (that is tamper resistant, water resistant, and designed to withstand daily wear and tear) strapped to the subject's ankle with two separate parts and is worn 24/7. The first bracelet component contains a sensor pack that measures ethanol vapor as it migrates through the skin to determine BAC. The second bracelet component contains electronics for tamper detection and system control, as well as collecting, storing, and transferring data via to the modem. A tamper-detection strap acts as an electronic link between the two components and secures the bracelet to the client's ankle. The SCRAM modem is placed in the offender's home and requires the offender to be in the same room at a predetermined time (allowing the bracelet to communicate with the modem) to retrieve all available data from the bracelet.
2.) The Modem is placed in the defendant's home. At a predetermined time each day, the defendant is required to be in the same room as the SCRAM Modem, triggering the Bracelet to "communicate" with the Modem. The Modem will retrieve all the data from the Bracelet. In the event of a positive reading or a tamper alarm, the bracelet will immediately begin looking for the SCRAM Modem, and the data will upload as soon as the defendant is within range.
3.) After the SCRAM Bracelet transmits its stored data to the SCRAM Modem, the modem sends all the data to SCRAMNET via a standard telephone line in the home, which forwards the data to a private, secure telephone network. The SCRAM Modem communicates alcohol readings, tamper alerts, and diagnostic data to SCRAMNET , and in turn, SCRAMNET uses the SCRAM Modem to download monitoring and reporting schedules to the SCRAM Bracelet. SCRAMNET is a web-based application managed by AMS and hosted by IBM Global Services. It is accessed via the internet using standard web browsers, so the supervising agency can easily control the testing, synchronization, and reporting schedules for each individual and can have round the clock access to all data via the easy to use application. During the day, SCRAMNET will notify the supervising authority of any possible alcohol readings, tamper alerts, or equipment malfunctions, so that agencies can quickly respond to offenders.

County Probation Work Program

The County Probation Work Program is used as an alternative sanction by the Court in lieu of jail time. Referrals are received from County Probation, Department of Corrections and the State Attorney Diversion Program. For both County Probation and the Department of Corrections the sanction is used as a condition of probation. County Probation supervises clients sentenced for misdemeanor offenses with, in most instances, a minimum of three months probation and a maximum penalty of one year imprisonment. Offenses vary from a minor possession charge to a second D.U.I. These clients complete an average of 111 work days per month.

The Department of Corrections refers defendants who have been placed on probation for two or more years. Offenses range from Burglary to Aggravated Assault with a Deadly Weapon. DOC probationers average approximately 72 completion days per month.

Administrative Order 95-1 authorizes the State Attorneys Office to operate a Misdemeanor Diversion Program. The defendant must be a first time offender of an eligible misdemeanor offense, such as Disorderly Conduct or Petit Theft. The defendant is required to attend an educational class, perform one day on the Work Program and pay a fine. Diversion clients complete an average 124 days per month.

The Leon County Probation Community Service/Work Program Coordinator instructs clients on the rules of the program and monitors compliance/ non-compliance. The Coordinator is responsible for documenting the completion status and disseminating this information to the referral source. Clients assigned to the Program are required to work 10 hours of manual labor for each day. On site supervision is provided by staff from the Leon County Division of Operations. Tasks may include: picking up litter, making and stacking sand bags, pulling weeds, cutting brush, graffiti removal and other duties as needed.

Each client is required to pay a $30.00 administrative fee and will be assessed an additional $30.00 fee if they schedule a work day and fail to report ("no show fee"). Any client with medical emergency or a death in the immediate family will not be assessed the "no show fee" with the necessary documentation.

During the period of October 1, 2003 through September 30, 2004, approximately 2,792 clients were assigned for a combined total of 3,703 days completed on the Work Program. At ten hours of labor per day for each client, approximately 37,030 hours of services were provided at a costs savings of $190,704.00. Of that total, clients from County Probation completed 1,497 days, 1,339 days completed by clients from the Diversion Program and 867 from clients referred by the Department of Corrections. There is a notable decrease in clients completing the work program in 2004. This may be attributed to the impact of the DOC zero tolerance policy. The increase in the no show rate from 22% (FY02/03) to 27% (FY03/04) may have also contributed to the decrease.

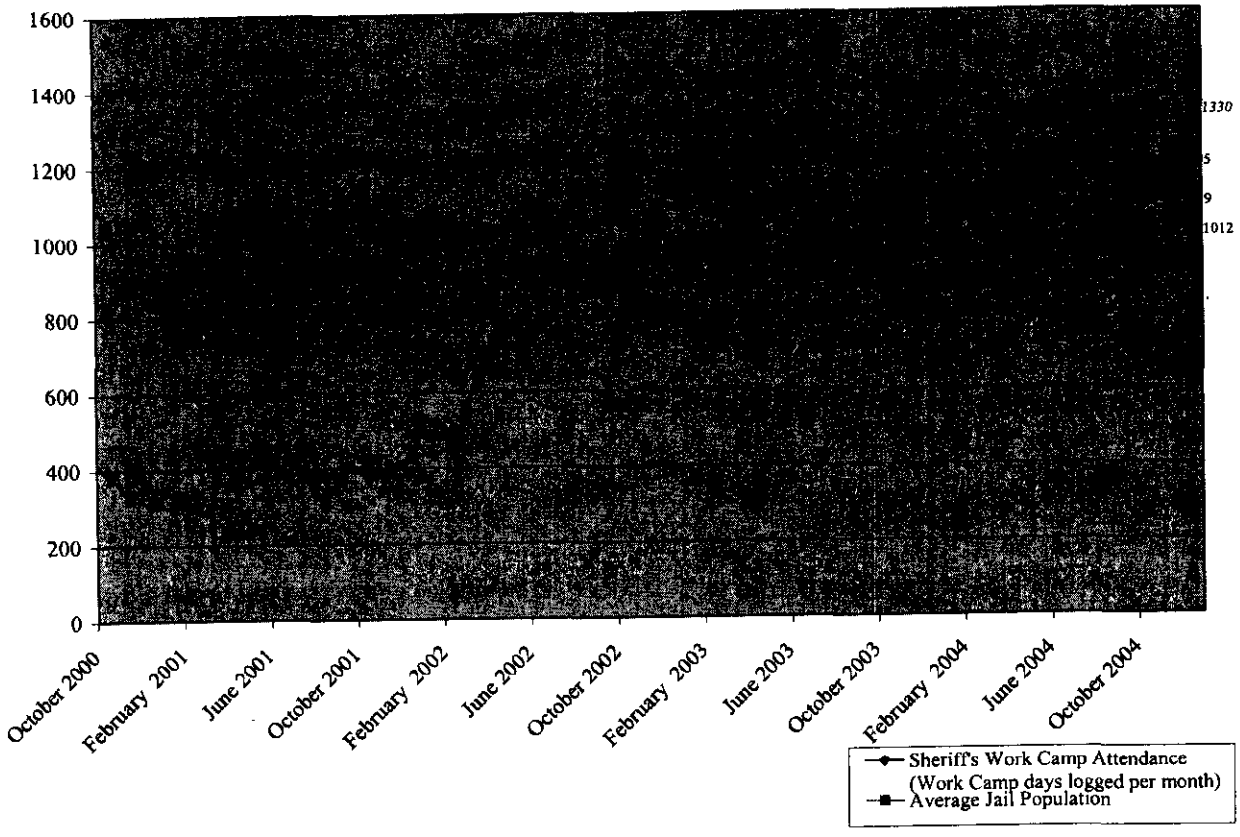
VI. SHERIFF'S WORK CAMP

During the FY01/02 budget process the Board funded eight new correctional officer positions in the Sheriff's budget to allow for expansion of the weekend work camp to a seven day operation. The resources to support this program were reallocated from savings resulting from the closure of the drill academy.

The following chart presents the growth in utilization of the Sheriff's Work Camp since its expansion in October 2001. This chart also demonstrates the average daily jail population during the same time period. It should be noted that currently, there is no means through CJIS by which to measure the impact utilization the Work Camp has on the overall jail population. However,

the expansion of this program has allowed more offenders to serve their sentence through the weekly work program while remaining in their jobs, with their families and in their communities.

Sheriff's Work Camp



The Sheriff's Office Jail Work Camp Program is a successful alternative to a jail sentence. In addition to keeping offenders out of the jail, the inmates of the Work Camp program provide important services to Leon County. (The Work Camp is averaging 40 people each day. This equates to approximately 2,209 man hours per week or 114,850 man hours of work per year.) The following agencies and organizations are a sample list of those that the Work Camp has provided inmate labor assistance: Habitat for Humanity, Mother's In Crisis, Boy Scout's of America, Leon County Schools, City of Tallahassee Parks and Recreations, Mosquito Control, Leon County Heath Department, Leon County Public Works, American Red Cross, The Salvation Army, Riley House, Ronald McDonald House, Department of Children and Family Services, Tallahassee Boys and Girls Club, Pyramid Inc., Tallahassee Community College, Florida State University, Red Hills Horse Trails, City of Tallahassee Streets and Drainage and Leon County Waste Management.

The Work Camp also provides inmate work crews to assist in picking up roadside trash on Leon County roads and streets.

VII. CONCLUSION AND SUMMARY FINDINGS & RECOMMENDATIONS

After reviewing the County's jail population, probation programs, and other facets of the local criminal justice system, the PSCC recommends that the Leon County Supervised PreTrial Release (SPTR) Program spear-head a pilot project utilizing existing SPTR staff resources and funding from the Leon County Sheriff's Office's Inmate Trust Fund for the lease of the SCRAM devices. Representatives from the Sheriff's Office, PreTrial Release, Management Services, and County Administration developed a concept pilot proposal on behalf of the PSCC. The three month pilot project period could begin October 1, 2005, with the lease of five SCRAM units. Depending upon the success of the first three months, as well as resource availabilities and impacts, the pilot project period may be extended an additional three months. Hours of operation to hook-up or remove the devices are recommended between 8:30 a.m. - 3:30 p.m., during normal County business days. Training of local staff and SCRAM device monitoring during the pilot project period would be provided by AMS.

Due to the funding sources, use of the SCRAM device will exclude probationers and will be limited to Leon County residents ordered to SPTR. It is recommended that the devices not be utilized on offenders ordered for GPS monitoring during this pilot period.

Staff is awaiting AMS' written proposal that will detail costs. The daily rental cost, including monitoring, is expected to be $10 - $12 per unit while it is in use. There is no daily charge for unutilized units.

The PSCC has also expressed interest in exploring the idea of a private restitution center for nonviolent criminals that would operate as a work camp under Sheriff Campbell's supervision. The PSCC is expected to address this idea at future meetings.

The PSCC will continue its charge of reviewing the jail population, improving upon criminal justice agency coordination, and reviewing alternative programs that help alleviate jail crowding while keeping community safety and health of its citizens as the primary responsibility and goal of the Council.

Attachment:
1A. 2004 Arrest Data by Agency in Leon County

County and Municipal Arrest Data
January - June 2004

Agency/County	Year	Total Arrest	Total Adult	Total Juvenile	Murder	Forcible Sex Offenses	Robbery	Aggravated Assault
Leon County	**2003**	**5,046**	**4,515**	**531**	**5**	**19**	**37**	**238**
FL037	**2004**	**5,134**	**4,566**	**568**	**2**	**17**	**48**	**193**
Leon County Sheriffs Office		1478	1358	120	0	4	5	54
Tallahassee Police Department		3073	2659	414	2	13	42	136
FDLE - Tallahassee		13	13	0	0	0	0	0
Leon-DEP Div of Law Enforce		7	7	0	0	0	0	0
Florida State University PD		276	270	6	0	0	1	1
Florida A&M University PD		39	38	1	0	0	0	2
Leon-Florida Game Comm		72	49	23	0	0	0	0
Florida Capitol Police		7	7	0	0	0	0	0
Leon-Division of Insurance Fraud		4	4	0	0	0	0	0
TCC Police Department		1	0	1	0	0	0	0
FHP - Tallahassee		164	161	3	0	0	0	0

COPY

INMATE HEALTH SERVICES AGREEMENT BETWEEN SHERIFF LARRY CAMPBELL AND PRISON HEALTH SERVICES, INC.

THIS AGREEMENT is made by and between Larry Campbell, as SHERIFF of Leon County, Florida, a County Constitutional Officer of the State of Florida, for the Leon County SHERIFF's Office (hereinafter referred to as "SHERIFF"), and Prison Health Services, Inc., a Delaware corporation, (hereinafter referred to as "PHS"), is entered into as of the 1st day of October, 2002. The SHERIFF and PHS shall hereinafter be collectively referred to as the "Parties". Services under this Agreement shall commence on October 1, 2002.

WITNESSETH:

WHEREAS, in accordance with Chapter 951, Florida Statutes, the SHERIFF has been designated by the Leon County Board of County Commissioners as the Chief Correctional Officer of the County Correctional System (hereinafter referred to as the "JAIL"); and

WHEREAS, the SHERIFF is therefore charged by law with the responsibility for obtaining and providing reasonably necessary medical, psychiatric, dental and other health care services for persons remanded to his care, custody, and control (hereinafter referred to as "inmates"), within the JAIL; and

WHEREAS, the said County Correctional System consists of the JAIL located at 535 Appleyard Drive, Tallahassee, Florida 32304; and

WHEREAS, the SHERIFF desires to provide for health care to inmates in accordance with applicable law; and

WHEREAS, the SHERIFF, which receives funding as approved by the Board of County Commissioners for the administration of the JAIL, desires to enter into this Agreement with PHS to promote this objective; and

WHEREAS, PHS is in the business of providing correctional health care services and desires to provide such services for the SHERIFF under the terms and conditions hereof,

NOW, THEREFORE, in consideration of the covenants and promises hereinafter made, the parties hereto agree as follows:

ARTICLE I: HEALTH CARE SERVICES

1.1 General Engagement. The SHERIFF hereby contracts with PHS to provide for the delivery of reasonably necessary medical, dental, and mental health care to individuals under the custody and control of the SHERIFF and incarcerated at the JAIL, except those individuals sentenced to and participating in the Sheriff's Work Program. Individuals who, during the arresting process by any state, county, or municipal law enforcement officer, sustains an injury at the time of a lawful arrest, or is found to have a pre-existing illness and immediately transported by the arresting agency to a designated hospital or medical facility prior to normal processing of such person into the JAIL, shall also be covered under this Agreement, subject to the limits established in Section 1.5. PHS enters into this Agreement according to the terms and provisions hereof.

1.2 Scope of General Services. The responsibility of PHS for medical care of an inmate commences after an inmate is taken into custody by any law enforcement agency with the intention of transporting the inmate to the JAIL for booking and PHS is given reasonable opportunity to assume management of the medical care of that inmate. It is required that the SHERIFF notifies the on-site PHS staff of any bookings performed outside the JAIL. PHS shall provide health care services for all persons committed to the custody of the JAIL, except individuals sentenced to and participating in the Sheriff's Work Camp Program and those identified in Section 1.7. PHS shall provide on a regular basis, all professional medical, dental, mental health (excluding in-patient psychiatric hospitalization in a psychiatric hospital), related health care and administrative services for the inmates, a comprehensive health evaluation of each inmate following booking into the JAIL in accordance with NCCHC and Florida Model Jail Standards, booking/intake health screenings, including medical evaluation for inmate work details, regularly scheduled sick call, nursing care, regular physician and dentist visits to the JAIL, hospitalization, mental health services, medical specialty services, emergency medical care, emergency ambulance services when medically necessary, medical records management, pharmacy services management, health education and training services, a quality assurance program, administrative support services, and other services, all as more specifically described herein.

1.3 Specialty Services. In addition to providing the general services described above, PHS shall provide to inmates of the JAIL and be responsible for the payment of special medical services including radiology services, laboratory services, and optometry services, including eyeglasses, to the extent such are determined to be medically necessary by PHS, as well as medically generated hazardous waste disposal. Where non-emergency specialty care is required and not rendered at the JAIL, PHS will make appropriate off-site arrangements for the rendering of such care and shall make arrangements with the SHERIFF for the transportation of the inmates in accordance with Section 1.9 of this Agreement.

1.4 Emergency Services. PHS shall provide and be responsible for the payment of emergency medical care, as medically necessary, to inmates through arrangements to be determined by PHS with local hospitals. PHS shall provide for qualified emergency ambulance transportation services when medically necessary in connection with off-site emergency medical treatment. Additionally, staff employed by the SHERIFF and visitors to the JAIL shall be treated within the JAIL for injuries and/or illnesses only in an emergency and/or upon request of the SHERIFF. PHS shall not be responsible for payment of emergency and follow-up services and transportation provided to SHERIFF's staff or visitors within the JAIL in the event of an emergency.

1.5 Hospitalization Services and Limitations on Medical Services. PHS will arrange for the admission of any inmate who, in the opinion of the Medical Director (hereinafter meaning a licensed PHS physician and designated as such) requires hospitalization, and will bear the costs thereof up to the limits set forth herein. Subject to the limits set forth herein, PHS will be responsible for all costs associated with hospitalization, all off-site and on-site specialty services, inclusive of diagnostic procedures, and emergency transportation services. Services rendered at the Jail by PHS staff will not be factored into the aggregate limits set forth herein.

"*Hospitalization*" refers to those services, which will be rendered in a hospital, which provides comprehensive medical care. Such services include inpatient hospitalization, physician fees associated with inpatient or outpatient care, ambulatory surgery, emergency ambulatory care, diagnostic and therapeutic radiology, laboratory and pathological capabilities, and physical medicine capabilities. "*Off-site medical specialty care*" refers to those services rendered by licensed medical specialists, which are not provided on-site at the Jail, and which are provided off-site in a hospital, physician's office or clinic, or other medical facility.

For each twelve (12) month period of the contract, PHS' liability for costs associated with the medical services for inmates rendered outside of the JAIL as previously defined will be limited as follows:

(a) PHS' total liability for hospital and off-site medical specialist care costs for all inmates will be limited to $500,000 per twelve (12) month contract period. Should the amount expended not reach $500,000 in any contract year, PHS will credit the SHERIFF against the fees paid by the SHERIFF or issue payment to the SHERIFF, as directed by the SHERIFF, an amount equal to ninety percent (90%) of the difference between the amount expended and $500,000. Any costs in excess of $500,000 are the responsibility of the SHERIFF.

(b) Included in the aggregate $500,000 annual liability limit are costs associated with protease inhibitors, as indicated by Exhibit C (attached), and viral load testing for HIV positive patients. Monthly summaries for these costs will be forwarded to SHERIFF.

The intent of this Section 1.5 is to define PHS' limit of costs for hospitalization and other medical services rendered outside of the JAIL. PHS will be responsible for the payment of all invoices associated with the provision of off-site services and will bill or credit the SHERIFF, at the end of each contract year. PHS shall have one hundred and fifty (150) days following the end of each contract period to pay all claims pertaining to the contract period.

In the event this Agreement should terminate prior to the end of the then current contract period, the aggregate limit will be prorated accordingly based on the fractional portion of the total contract period during which PHS actually provided services.

Once an inmate has been taken into the custody of the SHERIFF, PHS will be financially responsible for the cost of all medical treatment, subject to the limits noted in Section 1.5, for health care services regardless of the nature of the illness or injury or whether or not the illness or

injury occurred prior or subsequent to the individual's incarceration at the JAIL, once the inmate has been determined to be medically stabilized. An inmate shall be considered medically stabilized when the medical condition no longer requires immediate emergency medical care or outside hospitalization so that the inmate can be reasonably housed inside the JAIL.

PHS shall assume responsibility for "off the street" injuries in accordance with Section 901.35, Florida Statutes, subject to the limits set forth above. This includes medical treatment and care for injuries suffered during the arrest process, before the detainee is booked, but taken into custody by law enforcement to be housed at the JAIL. PHS shall be notified as soon as practicable and given reasonable opportunity to assume management of care.

1.6 Exceptions to Treatment. PHS shall not be financially responsible for significant changes in treatment standards, which are either not FDA approved at the start date of this contract or are not part of PHS' written protocols in use at the JAIL at the time this Agreement is entered into. Should any new drug classes or diagnostic tests be mandated and approved in relation to community health care standards for treatment and or required by the PHS Medical Director as necessary for the treatment of inmates housed at the JAIL, and the cost of such treatment, in total aggregate, would exceed 2% of the annual contract amount for any contract term, then the SHERIFF, and PHS shall agree to negotiate for additional compensation due PHS.

PHS shall not be responsible for medical costs associated with the medical care of any fetus or infants born to inmates. PHS shall provide health care services to pregnant inmates, but health care services provided to an infant following birth will not be the responsibility of PHS. PHS shall not be responsible for the costs or furnishing of any abortions unless medically necessary.

PHS will not be responsible for any medical testing or obtaining samples, which are forensic in nature, except as required by Florida Statutes 943.325, which mandates that individuals convicted of "any offense or attempted offense defined in Chapter 794 (Sexual Battery), Chapter 800 (Lewdness; Indecent Exposure), s. 782.04 (Homocide), s. 784.045 (Aggravated Battery), s. 812.133 (Carjacking), or 812.135 (Home Invasion Robbery) and, who is within the confines of the legal state boundaries, shall be required to submit two specimens of blood." Revisions of the Florida statutes pertaining to medical testing or obtaining samples, which are forensic in nature, which occur during the term of this agreement, will be considered a further obligation of PHS.

1.7 Inmates Outside the JAIL. Health care services are intended only for those inmates in the custody of the SHERIFF or other law enforcement agency lawfully arrested and to be booked into as well as in actual custody of the JAIL. This includes inmates booked into custody while in outside hospitals immediately after notification of such booking to the on-site PHS Medical staff and the allowance of a reasonable time for PHS to assume management of the individual's medical care. This also includes inmates under guard by the SHERIFF in outside hospitals. Such inmates will be included in the daily population count.

Inmates on any sort of temporary release (authorized or unauthorized), including, but not limited to, inmates temporarily released for the purpose of attending funerals or other family emergencies, inmates on escape status, inmates on pass, parole or supervised custody who do not sleep in the JAIL at night, will not be included in the daily population count, and will not be the responsibility of PHS with respect to any claim, liability, cost or expense for the payment or furnishing of health care services. The cost of medical services provided to inmates who become

ill or are injured while on temporary release will not be the financial responsibility of PHS until their return to the JAIL. This relates solely to the costs relating to the particular illness or injury incurred while on such temporary release. The cost of medical services for other illnesses and injuries will be the responsibility of PHS.

Inmates in the custody of other police agencies or other penal jurisdictions at the request of the SHERIFF are likewise excluded from the population count and are not the responsibility of PHS for the furnishing or payment of health care services.

1.8 Elective Medical Care. PHS will not be responsible for providing elective medical care to inmates. For purposes of the Agreement, "elective medical care" means medical care, which, if not provided, would not, in the opinion of PHS' Medical Director, cause the inmate's health to deteriorate or cause definite harm to the inmate's well-being. Such decisions concerning medical care shall be consistent with applicable laws and general medical standards. PHS will give notice to the SHERIFF of any referral of inmates for elective medical care prior to provision of such services.

1.9 Transportation Services. To the extent any inmate requires off-site nonemergency health care treatment including, but not limited to, hospitalization care and specialty services, for which care and services PHS is obligated to pay under this Agreement, the SHERIFF will, upon prior request by PHS, its agents, employees or contractors, provide transportation as reasonably available, provided that such transportation is reasonably scheduled in advance. When medically necessary, PHS shall provide all emergency ambulance transportation of inmates in accordance with Section 1.4 of this Agreement and subject to the limits set forth in Section 1.5.

1.10 Medical Services to Sheriff's Office Staff. PHS will provide annual testing for tuberculosis (PPD test) for all SHERIFF's newly sworn staff and correctional staff at the time of hire or exposure at no additional cost to the SHERIFF. The SHERIFF will be responsible for the cost of all testing supplies and materials.

ARTICLE II: PERSONNEL

2.1 Staffing. PHS shall provide medical, mental health, dental, technical and support personnel as necessary for the rendering of health care services to inmates at the JAIL as described in and required by this Agreement. The chart attached as Exhibit A includes the agreed-upon staffing matrix necessary to provide the health care and support services required by the JAIL for an inmate population of up to 1,250 inmates.

The staffing matrix is based on the assumption that there will be up to 1,250 inmates. Should the inmate population increase to a level greater than 1,250 inmates for a period of sixty (60) days or longer, additional health care staffing beyond the positions noted above might be necessitated. Should a sustained increase occur, PHS reserves the right to review the staffing and contract price and, with the SHERIFF's participation and approval, which shall not be unreasonably withheld, make necessary adjustments in staffing and contract price in order to accommodate any additional staff positions which may be needed to serve the increased inmate population. Should a sustained decrease in inmate population occur for a period of sixty (60) days

or longer, PHS and the SHERIFF reserves the right to decrease staffing to an appropriate level for the population.

Should a sustained decrease in population occur such that there is a variance in population for a sustained period of sixty (60) days, PHS will be able to decrease staffing until population is at the prior level, if such decrease can occur without a reduction in the level of service to the remaining population. The SHERIFF will receive a credit for the reduction in staff if due to the sustained decrease in population.

2.2 Staffing Penalties. After the first sixty (60) days of the contract period, for each position governed by the staffing matrix included as Exhibit A of this Agreement, a penalty will be imposed by the SHERIFF for any unfilled hours. For each unfilled hour of such staff time, the SHERIFF will deduct from its monthly payment to PHS at the average hourly salary rate, plus benefits, for the position as defined in Exhibit B. In all cases, employees may be used to cover like positions when their credentials are equal to or exceed the credentials required for such similar position.

Unfilled hours include those hours, which are not filled due to voluntary or involuntary termination or any other reason or incident resulting in the position being unfilled. However, unfilled hours will not include those hours not filled due to illness, annual, or personal leave. If the hours remain unfilled in excess of fifteen (15) days an amount will be payable to the SHERIFF, as set forth above.

In the event of staff shortages, "agency" or "pool" nurses shall not exceed 15% of the total staffing pattern for any monthly period. In the event that PHS exceeds this limit, a charge back equal to one hundred percent (100%) of the average hourly salary rate for each of the positions shall be assessed for each hour PHS exceeds the fifteen percent (15%) cap.

2.3 Licensure, Certification and Registration of Personnel. All personnel provided or made available by PHS to render services hereunder shall be licensed, certified or registered, as appropriate, in their respective areas of expertise as required by applicable Florida law. Each license or certification shall be on file at a central location as mutually agreed upon. All prospective PHS employees will be screened by the SHERIFF and no employee will be allowed on duty until PHS is notified of security clearance.

2.4 Sheriff's Satisfaction with Health Care Personnel. If the SHERIFF becomes dissatisfied with any health care personnel provided by PHS hereunder, or by any independent contractor, subcontractors or assignee, PHS, in recognition of the sensitive nature of correctional services, shall, following receipt of written notice from the SHERIFF of the grounds for such dissatisfaction and in consideration of the reasons therefor, shall exercise its best efforts to resolve the problem. If the problem is not resolved satisfactorily to the SHERIFF, the SHERIFF may revoke the employee's right to enter the JAIL or PHS shall remove or shall cause to be removed any employee, agent, independent contractor, subcontractor, or assignee about whom the SHERIFF has expressed dissatisfaction. The SHERIFF shall have the right of disapproval of any person hired or contracted by PHS. Should removal of an individual become necessary, PHS will be allowed thirty (30) days from date of removal to find an acceptable replacement, without penalty or prejudice to the interests of PHS.

2.5 Use of Inmates in the Provision of Health Care Services. Inmates shall not be employed or otherwise engaged by either PHS or the SHERIFF in the direct rendering of any health care services. Upon prior written approval of the SHERIFF, inmates may be used in positions not involving the rendering of health care services directly to inmates.

2.6 Subcontracting and Delegation. In order to discharge its obligations hereunder, PHS will engage certain health care professionals as independent contractors rather than as employees. The SHERIFF may request to approve such professionals, but approval will not be unreasonably withheld. Subject to the approval described above, the SHERIFF consents to such subcontracting or delegation. As the relationship between PHS and these health care professionals will be that of independent contractor, PHS will not be considered or deemed to be engaged in the practice of medicine or other professions practiced by these professionals. PHS will not exercise control over the manner or means by which these independent contractors perform their professional medical duties. However, PHS shall exercise administrative supervision over such professionals necessary to ensure the strict fulfillment of the obligations contained in this Agreement. For each agent and subcontractor, including all medical professionals, physicians, dentists and nurses performing duties as agents or independent contractors of PHS under this Agreement, PHS shall provide the SHERIFF proof, prior to the effective date of this agreement, that there is in effect a professional liability or medical malpractice insurance policy, as applicable coverage for each health care professional identified herein, in an amount of at least One million dollars ($1,000,000) coverage per occurrence and Three million dollars ($3,000,000) aggregate. If requested by the SHERIFF, PHS will provide to the SHERIFF copies of subcontractor agreements providing service warranted under the Agreement.

2.7 Discrimination. During the performance of this Agreement, PHS, their employees, agents, subcontractors, and assignees agree as follows:

(a) They will not discriminate against any employee or applicant for employment because of race, color, religion, sex, age, Vietnam Veteran status, disability as defined in the Americans with Disabilities Act or national origin, except where age, religion, sex, disability or lack thereof or national origin is a bona fide occupational qualification reasonably necessary to the normal operation of the contractor. They will agree to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

(b) In all solicitations or advertisements for employees, they will state that it is an equal opportunity employer.

(c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

ARTICLE III: ACCREDITATION

3.1 Obligation of PHS. PHS' services shall be designed to meet the standards promulgated/developed by the National Commission on Correctional Health Care for Jails

(NCCHC), Florida Correctional Accreditation Commission (FCAC) and the Florida Model Jail Standards. PHS will cooperate fully with the SHERIFF in all efforts to attain and maintain formal accreditation of the JAIL's health care program. PHS will be responsible for the payment of the fees for attaining NCCHC accreditation as well as those associated with the medical portion of FCAC and Florida Model Jails. Any deficiency in the performance of health care services under this Agreement in the Leon County Main Jail resulting in notice from any regulatory or accrediting organization may constitute a material breach of this Agreement and shall be rectified immediately provided that such a breach is directly attributed to PHS. Failure to rectify any such deficiency within a thirty (30) day cure period may result in causing the SHERIFF, in his sole discretion, to terminate this Agreement. In the event accreditation from the NCCHC in not attained within 18 months of the contract start date and is not maintained thereafter during the term of this Agreement for failure on the part of PHS to comply with NCCHC standards, then PHS will pay a penalty of Fifty Thousand and 00/100 Dollars ($50,000.00) to the SHERIFF as liquidated damages.

This obligation shall include the providing of written reports, on-site reviews, preparation of forms and applications and attendance at meetings as required by the SHERIFF. PHS shall not be responsible for NCCHC requirements not under PHS' direct control or within the scope of PHS services.

ARTICLE IV: EDUCATION

4.1 Inmate and Staff Education. PHS shall conduct an ongoing health education program for inmates at the JAIL with the objective of raising the level of inmate health and health care. If the SHERIFF so desires, PHS shall conduct the same program for correctional officers at the JAIL.

PHS staff will provide relevant training to SHERIFF's staff on at least a quarterly basis on topics agreed upon by both parties.

4.2 Medical Services Staff Education. PHS will require that its medical, professional and para-professional staff receive all necessary and requisite legal and statutorily mandated in-service, annual or proficiency training and other such professional or para-professional education and training programs needed to provide current proficiency in the professional's or para-professional's particular medical discipline or specialty.

ARTICLE V: REPORTS AND RECORDS

5.1 Medical Records. PHS shall cause and require to be maintained a complete and accurate medical record for each inmate who has received health care services from or at the direction of PHS. Each medical record will be maintained in accordance with applicable laws, NCCHC standards, FCAC standards, and the SHERIFF's policies and procedures. The medical records shall be kept separate from the inmate's confinement record. A complete legible copy of the applicable medical record shall be available, at all times, to the SHERIFF and may be available to accompany each inmate who is transferred from the JAIL to another location for off-site services or transferred to another institution. Medical records shall be kept confidential. Subject to applicable law regarding confidentiality of such records, PHS shall comply with Florida law and the SHERIFF's policy with regard to access by inmates and JAIL staff to medical records. No

information contained in the medical records shall be released by PHS except as provided by the SHERIFF's policy, by a court order, or otherwise in accordance with the applicable law. PHS shall provide all medical records, forms, jackets, and other materials necessary to maintain the medical records. Upon the expiration or termination of this Agreement, all medical records shall be delivered to and remain with the SHERIFF. However, the SHERIFF shall, within the limits of applicable law, provide PHS with reasonable ongoing access to all medical records even after the termination/expiration of this Agreement to enable PHS to properly prepare for litigation or anticipated litigation or any other legal or regulatory action brought or threatened by third persons in connection with services rendered during the term hereof.

PHS agrees to coordinate any and all public records requests received by PHS requesting inmate medical records with the SHERIFF's Custodian of Records.

5.2 HIPAA Compliance. PHS shall comply with all Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements relating to PHS' responsibilities under this Agreement.

5.3 Regular Reports by PHS to the SHERIFF. PHS shall provide to the SHERIFF, on a date and in a form mutually acceptable to PHS and the SHERIFF, monthly and annual reports relating to services rendered under this Agreement. PHS shall submit monthly and other periodic reports to the Director of the Jail or the SHERIFF's Health Services Representative, concerning and reflecting on the overall health of the inmates committed to the custody of the SHERIFF. Such reports shall be submitted on a regular, periodic, or as requested basis to be determined by mutual written agreement of PHS and the SHERIFF. PHS will fully cooperate with the SHERIFF to respond to reporting requests to support any provision or section of this Agreement, without any additional charge, fee or assessment to the SHERIFF.

5.4 Third Party Reimbursement. PHS will seek and obtain from any inmate information concerning any health insurance the inmate might have that would cover services rendered by PHS hereunder, and the SHERIFF will cooperate fully with PHS in its efforts to secure this information. PHS will be responsible for the provision of personnel for the coordination and management oversight of all potential third party payment efforts. PHS will not make payment for any offsite inmate health care until all third party payment efforts have been exhausted, such efforts will not include litigation. All third party remuneration that is recovered or credited because of the efforts to collect payment by PHS from any third party source or entity, including without limitation, workers compensation insurance, commercial medical insurance, federal, state or local health care benefits or programs, will be returned, paid or credited to the SHERIFF's office, as directed by the SHERIFF. SHERIFF will receive a monthly report outlining third party reimbursement efforts made by PHS.

PHS will require that anyone acting on its behalf or providing any medical service to an inmate will seek reimbursement for any such medical services, as allowed by law, in accordance with the provisions of F.S. 901.35 (except for F.S. 901.35(2) (a), (b), as it may be applicable to the Board of County Commissioners for Leon County) and F.S. 951.032.

5.5 Inmate Information. Subject to the applicable Florida law, in order to assist PHS in providing the best possible health care services to inmates, the SHERIFF will provide PHS with

information pertaining to inmates that PHS and the SHERIFF mutually identify as reasonable and necessary for PHS to adequately perform its obligations hereunder.

5.6 PHS Records Available to the SHERIFF with Limitations on Disclosure. PHS shall make available to the SHERIFF, at the SHERIFF's request, all records, documents and other papers relating to the direct delivery of health care services to inmates hereunder. The SHERIFF understands that many of the systems, methods, procedures, written materials and other controls employed by PHS in the performance of its obligations hereunder are proprietary in nature and will remain the property of PHS. Information concerning such may not, at any time, be used, distributed, copied or otherwise utilized by the SHERIFF, except in connection with the delivery of health care services hereunder, and as permitted or required by law, unless such disclosure is approved in advance in writing by PHS.

5.7 SHERIFF's Records Available to PHS with Limitations on Disclosure. During the term of this Agreement and for a reasonable time thereafter, the SHERIFF will provide PHS, at PHS' request, SHERIFF's records relating to the provision of health care services to inmates as may be reasonably requested by PHS or as are pertinent to the investigation or defense of any claim related to PHS' conduct. Consistent with applicable law, the SHERIFF will make available to PHS such records as are maintained by the SHERIFF, hospitals and other outside health care providers involved in the care or treatment of inmates (to the extent the SHERIFF has any control over those records) as PHS may reasonably request. Any such information provided by the SHERIFF to PHS that the SHERIFF considers confidential and clearly labeled confidential shall be kept confidential by PHS and shall not, except as may be required by law, be distributed to any third party without the prior written approval of the SHERIFF.

5.8 Florida Public Record Law. PHS acknowledges that it is familiar with the provisions of Florida's Public Records Law (Chapter 119, F.S.) and all of its records as they pertain to health care services for the SHERIFF are subject to the provisions of the Public Records Law of Florida, unless specifically exempted under Chapter 119, Florida Statutes, or other such provisions of Florida law providing for the confidentiality of medical records. In the event that PHS should assert any proprietary or confidential status to any of its systems, methods, procedures or written materials and other controls employed by PHS in the performance of its obligation pursuant to this Agreement, then PHS shall assert such claim on its own, and shall defend and hold harmless the SHERIFF, the SHERIFF's employees, officers, appointees and agents against all liabilities for PHS' failure to comply with the requirements of the law with regard to the release of records.

ARTICLE VI: SECURITY

6.1 General. PHS and the SHERIFF understand that adequate security services are necessary for the safety of the agents, employees and subcontractors of PHS as well as for the security of inmates and SHERIFF's staff, consistent with the correctional setting. The SHERIFF will use reasonable efforts to provide sufficient security to enable PHS, and its personnel, to safely and adequately provide the health care services described in this Agreement. PHS, its staff and personnel, understand that the JAIL in which services will be rendered is a detention or jail facility and that working in such a facility involves inherent dangers. PHS, its staff and personnel further understand that the SHERIFF cannot guarantee anyone's safety in such a facility and nothing herein shall be construed to make the SHERIFF, his deputies or employees a guarantor of the safety of PHS employees, agents or subcontractors, including their employees.

In the event that any recommendation by PHS for particular health services for any inmate or transfers to a medical facility should not be implemented and carried out for security reasons, PHS will be released from professional liability for any damages resulting from any such decision on the part of the SHERIFF not to respond or to institute a requested transfer of any inmate.

6.2 Loss of Equipment and Supplies. The SHERIFF shall not be liable for loss of or damage to equipment and supplies of PHS, its agents, employees or subcontractors unless such loss or damage was caused by the negligence of the SHERIFF or his employees.

6.3 Security During Transportation Off-Site. The SHERIFF will provide security as necessary and appropriate in connection with the transportation of any inmate between the JAIL and any other location for off-site services as contemplated herein.

ARTICLE VII: OFFICE SPACE, EQUIPMENT, INVENTORY AND SUPPLIES

7.1 General. The SHERIFF agrees to provide PHS with office space, facilities, equipment (including office furniture) and utilities sufficient to enable PHS to perform its obligations hereunder. PHS will supply and be responsible for payment of telephone carrier services and equipment within the Jail for local and long distance access for use of its personnel. PHS shall provide all necessary office supplies, medical supplies, and additional equipment necessary to comply with the terms of this Agreement. The SHERIFF will provide necessary maintenance and housekeeping of the office space and the medical facility. PHS agrees it has inspected the JAIL and medical office space and that such space and facilities are sufficient for its agents, employees and subcontractors to perform all of the obligations required under this Agreement. SHERIFF shall be responsible for providing substitute space should the designated medical facility becomes unsafe for any reason.

7.2 Delivery of Possession. The SHERIFF will provide to PHS, beginning on the date of commencement of this Agreement, possession and control of all medical and office equipment and supplies, which are the SHERIFF's property, in place at the JAIL's health care unit. At the termination of this or any subsequent Agreement, PHS will return to the SHERIFF possession and control of all supplies, medical and office equipment, in working order, reasonable wear and tear excepted, which were in place at the JAIL's health care unit prior to the commencement of services under this Agreement and/or purchased by the SHERIFF during the term of this agreement.

7.3 Maintenance and Replenishment of Equipment. PHS will maintain all SHERIFF and PHS equipment necessary for the performance of this contract in working order during the term of this Agreement. Based on input from the PHS Medical Administrator and in consultation with the SHERIFF, the SHERIFF will consider submitting an annual budget for capital equipment items, with a value in excess of $2,500.00, necessary to provide services in the JAIL. The cost of all necessary equipment purchased and/or leased with a value or cost in excess of $2,500.00 will be split 50/50 between the SHERIFF and PHS with ownership reverting to the SHERIFF upon termination of the Agreement.

7.4 General Maintenance Services. The SHERIFF will provide for each inmate receiving health care services the same services and facilities provided by the SHERIFF for all

inmates at the JAIL including, but not limited to, daily housekeeping services, dietary services, building maintenance services, personal hygiene supplies and services, and linen supplies.

7.5 Supplies. PHS warrants and represents that the quality and quantity of supplies on hand during this Agreement will be sufficient to enable PHS to perform its obligations hereunder.

ARTICLE VIII: TERM AND TERMINATION OF AGREEMENT

8.1 Term. This Agreement will be effective at 12:01 a.m. on October 1, 2002. The initial term of this Agreement shall be three years. This Agreement is renewable under like terms for two (2) additional one (1) year terms thereafter, unless any of the parties delivers written notice of non-renewal to the other party at least ninety (90) days prior to the expiration of the then-existing term, in which event, this Agreement will terminate upon the expiration of the then-existing term.

8.2 Termination. This Agreement may be terminated as otherwise provided in this Agreement or as follows:

(a) Termination by Agreement. In the event that each of the parties mutually agrees in writing, this Agreement may be terminated on the terms and date stipulated therein.

(b) Termination by Cancellation. This Agreement may be cancelled without cause by the SHERIFF or PHS upon one hundred twenty (120) days prior written notice in accordance with Section 11.3 of this Agreement.

(c) Termination for Default. In the event either parties shall give notice to the others that such other party has materially defaulted in the performance of any of its material obligations hereunder and such default shall not have been cured within thirty (30) days following the giving of such notice in writing, the party giving the notice shall have the right immediately to terminate this Agreement, provided, however, that the cure period shall be limited to ten (10) days if the default is failure by the SHERIFF to timely make any payments due to PHS hereunder.

(d) Annual Appropriations and Funding. Failure of the Leon County Board of County Commissioners or other funding body to authorize or appropriate funds sufficient for the SHERIFF to meet his obligations hereunder.

(e) Immediate Termination by the SHERIFF: The SHERIFF, at the SHERIFF's sole discretion, may terminate this Agreement immediately upon the occurrence of any of the following events:

1) The insolvency, bankruptcy, or receivership of PHS;
2) PHS fails to maintain insurance in accordance with the Insurance Section of this Agreement, unless PHS' insurance carrier ceases to provide coverage without giving reasonable notice allowing PHS to obtain

replacement coverage. In such circumstances, PHS shall be allowed reasonable time to solicit and bind new coverage without being in default or otherwise penalized under the terms of this Agreement. PHS shall use all reasonable efforts to obtain replacement coverage.

(f) Election or Appointment of Sheriff other than Larry Campbell: Should a Sheriff other than Larry Campbell be elected or appointed during the initial term of this Agreement or any renewable period, the Agreement may be cancelled by the new elected or appointed Sheriff upon a ninety (90) day written notice provided to PHS.

8.3 Responsibility for Inmate Health Care. Upon termination of this Agreement, all of PHS' responsibility for providing health care services to all inmates, including inmates receiving health care services at sites outside the JAIL, will terminate.

ARTICLE IX: COMPENSATION

9.1 Base Compensation. The SHERIFF will pay to PHS the base price sum of Three Million Ninety-Nine Thousand Six Hundred Seventy-Two and 00/100 Dollars ($3,099,672.00) for the period of October 1, 2002 through September 30, 2003, for the daily average base inmate population of 1,050, payable in twelve (12) equal monthly installments of Two Hundred Fifty-Eight Thousand Three Hundred Six and 00/100 Dollars ($258,306.00) each. PHS will invoice the SHERIFF fifteen (15) days before the first day of the month for which services will be rendered The SHERIFF agrees to pay PHS on or before the thirtieth (30th) day of the month for which services will be rendered. In the event this Agreement should terminate or be amended on a date other than the end of any calendar month, compensation to PHS will be prorated accordingly based on the fractional portion of the month during which PHS actually provided services.

For the period of October 1, 2003 through September 30, 2004, the SHERIFF will pay PHS the sum of Three Million Three Hundred Sixteen Thousand Eight and 00/100 Dollars ($3,316,008.00) for a daily average base population of 1,100, payable in twelve (12) equal monthly installments of Two Hundred Seventy-Six Thousand Three Hundred Thirty-Four and 00/100 Dollars ($276,334.00) each. PHS will bill the SHERIFF fifteen (15) days before the first day of the month for which services will be rendered and the SHERIFF agrees to pay PHS on or before the thirtieth (30th) day of the month for which services will be rendered. In the event this Agreement should terminate or be amended on a date other than the end of a calendar month, compensation will be prorated accordingly based on the fractional portion of the month during which PHS actually provided services.

For the period of October 1, 2004 through September 30, 2005, the SHERIFF will pay PHS the sum of Three Million Five Hundred Forty-Seven Thousand Six Hundred Twenty and 00/100 Dollars ($3,547,620.00) for a daily average base population of 1,175, payable in twelve (12) equal monthly installments of Two Hundred Ninety-Five Thousand Six Hundred Thirty-Five and 00/100 Dollars ($295,635.00) each. PHS will bill the SHERIFF fifteen (15) days before the first day of the month for which services will be rendered and the SHERIFF agrees to pay PHS on or before the thirtieth (30th) day of the month for which services will be rendered. In the event this Agreement should terminate or be amended on a date other than the end of a calendar month, compensation

will be prorated accordingly based on the fractional portion of the month during which PHS actually provided services.

9.2 Increases/Decreases in Inmate Population. For the period of October 1, 2002 through September 30, 2003, a per diem rate of $2.04 will be applied to the monthly base compensation for each inmate in excess of the Average Monthly base population (beyond a 24-hour period) of 1,100. Should the Average Monthly base population be less than 1,000, the SHERIFF will receive a credit of $2.04 per inmate per day for the difference. The maximum credit applied per month will not exceed 50 inmates.

For the period of October 1, 2003 through September 30, 2004, a per diem rate of $2.14 will be applied to the monthly base compensation for each inmate in excess of the Average Monthly base population (beyond a 24-hour period) of 1,150. Should the Average Monthly base population be less than 1,050, the SHERIFF will receive a credit of $2.14 per inmate per day for the difference. The maximum credit applied per month will not exceed 50 inmates.

For the period of October 1, 2004 through September 30, 2005, a per diem rate of $2.25 will be applied to the monthly base compensation for each inmate in excess of the Average Monthly base population (beyond a 24-hour period) of 1,200. Should the Average Monthly base population be less than 1,100, the SHERIFF will receive a credit of $2.25 per inmate per day for the difference. The maximum credit applied per month will not exceed 50 inmates.

The average daily population counts are added for each day of the month and divided by the number of days in the month to determine the average monthly inmate population. The excess, if any, over the inmate population caps will be multiplied by the per diem rate and the number of days in the month to arrive at the increase in compensation payable to PHS for the month.

For example, if there is an excess above the monthly inmate cap of five (5) inmates as the monthly average at the end of the month, then PHS shall receive additional compensation of five (5) times the number of days in the month times the per diem rate for the contract year. If in the month of August (31 days) the average monthly population is five (5) inmates above the base and the per diem rate is $2.04, then the additional compensation payable to PHS is 5 X 31 X $2.04 = $316.20.

This per diem is intended to cover additional costs in those instances where minor, short-term increases in the inmate population result in the higher utilization of routine supplies and services. However, the per diem is not intended to provide for any additional fixed costs, such as new staffing positions, which might prove necessary if the inmate population exceeds 1,250 for a period of 60 (sixty) or more days. In such cases, PHS reserves the right to increase its staffing complement and adjust its contract price, upon consultation and approval from the SHERIFF, in order to continue to provide services to the increased number of inmates and maintain the quality of care. This would be done with the full knowledge and approval of the SHERIFF, at which time the base inmate population will be adjusted accordingly.

Should the SHERIFF designate any other Leon County site as a JAIL requiring the provision of health care services by PHS, the parties agree to negotiate the additional staff and compensation prior to PHS commencing services at the newly designated facility.

9.3 Compensation for Renewal Terms. Pricing will be adjusted for the renewal terms based on the mutual written agreement of the SHERIFF and PHS, not to exceed the most recent percentage change in the Medical Care Component of the CPI for all Urban Consumers for the South Region, or 6%, whichever is lower.

9.4 Inmates from Other Jurisdictions. Medical care rendered within the JAIL to inmates from other jurisdictions housed in the JAIL pursuant to contracts between the SHERIFF and such other jurisdictions will be the responsibility of PHS. PHS will arrange medical care that cannot be rendered in the JAIL, but PHS shall have no financial responsibility for such services.

9.5 Responsibility for Inmates in the Sheriff's Work Camp Program. Notwithstanding any other provisions of this Agreement to the contrary, the parties agree that inmates assigned to Sheriff's Work Camp Program are personally responsible for the costs of any medical services provided to them. PHS shall assist with arranging the necessary transportation for these inmates to obtain medical care.

9.6 Changes. If any statute, rule or regulation is passed or any order issued or any statute or guideline adopted or interpretation made, or additional facilities are opened that materially changes the scope of services or materially increases the cost to PHS of providing health care services hereunder, PHS and the SHERIFF agree to negotiate additional compensation to be paid by the SHERIFF to PHS as a result of such changes, provided, however, that if the parties are unable to agree on appropriate compensation, the matter shall be submitted to arbitration according to the provisions of Section 11.7 hereof.

ARTICLE X: LIABILITY AND RISK MANAGEMENT

10.1 Insurance. At all times during this Agreement, PHS shall maintain Professional Liability insurance covering PHS, its employees, its officers and agents in the minimum amount of at least one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate annually. Physicians and dentists provided by PHS will be included in the coverage. A tail policy or a policy that continues coverage for the services performed during the contract period will be maintained for an appropriate period in accordance with the Florida Statute of Limitations. The SHERIFF shall be listed as an additional insured. In the event that the coverage changes, PHS shall provide the SHERIFF with thirty (30) days notice in writing. PHS shall also provide thirty (30) days notice to the SHERIFF, in writing, of any reduction in policy amounts or cancellation of insurance coverage.

PHS will maintain over the term of this Agreement, Comprehensive General Liability coverage of at least $1,000,000 bodily injury and property damage, combined single limit.

PHS will maintain over the term of this Agreement, Worker's Compensation Insurance for all of its employees connected with the work of this Agreement and in any case of subcontracting, will require that the subcontractor have sufficient coverage as well. Such insurance will comply fully with the Florida Worker's Compensation Law.

10.2 Lawsuits Against the County and SHERIFF. In the event that any lawsuit (whether frivolous or otherwise) is filed against either Leon County, the SHERIFF, his employees and agents

based on or containing allegations concerning medical care by PHS to inmates or on the performance of PHS's employees, agents, subcontractors or assignees, the parties agree that PHS, its employees, agents, subcontractors, assignees or independent contractors, as the case may be, may be joined as parties defendant in any such lawsuit and shall be responsible for their own defense and any judgments rendered against them. Nothing herein shall prohibit any of the parties to this Agreement from joining the remaining parties hereto as defendants in lawsuits filed by third parties.

10.3 Indemnity. PHS agrees to indemnify and hold harmless, pay the cost of defense, including attorney's fees, and save the SHERIFF, his officers, appointees, agents and employees from any claim, action, lawsuit, loss, damage, cost, charge, judgments, liabilities, or expense of any kind whatsoever arising out of any act, action, neglect, omission or failure to act by PHS, including but not limited to, any claims, amounts or injuries covered under the Workers' Compensation laws, except as a third party claim outside Workers' Compensation, resulting or arising from PHS' obligations and duties under this Agreement, except that neither PHS nor any of its subcontractors shall be liable for any injury or damage caused by or resulting from the negligence of the SHERIFF, his officers, agents and employees.

It is the express understanding of the parties hereto that PHS shall provide the actual health care services, and have complete responsibility for the such health care services provided by its employees, agents, or subcontractors and any lawsuit arising solely out of such delivery of health care services. PHS expressly agrees that employees assigned by PHS to provide health care services pursuant to this Agreement are employees of PHS and not the SHERIFF, and the SHERIFF will not be liable or responsible for the PHS employees', agents', or subcontractors' acts or omissions, whether by negligence or by deliberate act.

Notwithstanding other provisions of this section, the SHERIFF shall have no obligation to provide legal counsel or a legal defense to PHS in the event that a suit, claim, for action of any character or nature is brought by any person not a party to this Agreement against PHS as a result of or relating to PHS' duties, obligations, and performances pursuant to this Agreement. The SHERIFF shall have no obligation for the payment of any judgment or the settlement of any claims made against PHS as a result of or relating to PHS' obligations, duties, and performances pursuant to this Agreement.

In no event however, shall PHS' obligations in this section apply or extend to:

a) any claim, liability, cost or expenses arising or incurred at any time in connection with treatment of any inmate's injury if such treatment was not within the responsibility of PHS' care pursuant to this Agreement; or

b) any claim, liability or cost arising out of the acts or omissions of any SHERIFF's officers, agents or employees which: prevent an inmate from receiving medical care as directed by PHS; to obtain prompt medical review or examination by PHS' employees or contractors.

Nothing herein is intended to or shall be construed to waive any rights the SHERIFF may have under the laws of Florida, included but not limited to, the provisions of Section 768.28 of the Florida Statutes.

ARTICLE XI: MISCELLANEOUS

11.1 Independent Contractor Status. The parties acknowledge that PHS is an independent contractor and that all medical care decisions will be the sole responsibility of PHS. Nothing in this Agreement is intended nor shall be construed to create an agency relationship, an employer/employee relationship, a joint venture relationship or any other relationship allowing the SHERIFF to exercise control or direction over the manner or method by which PHS, its employees, agents, assignees or its subcontractors perform hereunder.

11.2 Assignment and Subcontracting. PHS shall not assign or subcontract this Agreement, in whole or in part, to any other entity or person without the express written consent of the SHERIFF, which consent shall not be unreasonably withheld. Any such assignment or subcontract shall include the obligations contained in this Agreement. Any assignment or subcontract shall not relieve PHS of its independent obligation to provide the services and be bound by the requirements of this Agreement. The SHERIFF and PHS each binds itself, its successors, assigns and legal representatives to the other party hereto and to the successors, assigns and legal representatives of such other party in respect to all covenants, agreements and obligations contained herein. SHERIFF for purposes of this agreement shall include Larry Campbell or his designee.

11.3 Notice. Unless otherwise provided herein, all notices or other communications required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been duly given if delivered personally in hand or sent by certified mail, return receipt requested, postage prepaid, and addressed to the appropriate party at the following address or to any other person at any other address as may be designated in writing by the parties:

(a) Sheriff Larry Campbell:

Sheriff Larry Campbell
Sheriff of Leon County, Florida
2825 Municipal Way
Tallahassee, FL 32302

With copies to:

Captain Scott Bakotic
Chief Administrative Officer
2825 Municipal Way
Tallahassee, FL 32302

(b) PHS

Gerard Boyle, President
Prison Health Services, Inc.
105 Westpark Drive, Suite 200
Brentwood, Tennessee 37027

With a copy to:

General Counsel
America Service Group Inc.
105 West Park Drive, Suite 200
Brentwood, Tennessee 37027

Notices shall be effective upon receipt.

11.4 Governing Law. This Agreement and the rights and obligations of the parties hereto shall be governed by, and construed according to, the laws of the State of Florida and venue shall be Leon County, Florida.

11.5 Entire Agreement. This Agreement constitutes the entire agreement of the parties and is intended as a complete and exclusive statement of the promises, representations, negotiations, discussions and agreements that have been made in connection with the subject matter hereof. No modifications or amendments to this Agreement shall be binding upon the parties unless the same is in writing and signed by the respective parties hereto. All prior negotiations, agreements and understandings with respect to the subject matter of this Agreement are superseded hereby.

11.6 Amendment. This Agreement may be amended or revised only in writing and signed by all parties.

11.7 Dispute Resolution. Any controversy or claim arising out of or relating to this contract, or the breach thereof, shall be first sent to mediation for possible resolution. If mediation does not result in resolution, the parties agree to submit the dispute(s) to binding arbitration administered by the American Arbitration Association under its Commercial Arbitration Rules and judgement on the award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof. The parties agree to share equally the cost of the mediation.

11.8 Waiver of Breach. The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provision hereof.

11.9 Enforcement. In the event either party incurs legal expenses or costs to enforce the terms of this Agreement, the prevailing party in any arbitration/litigation proceeding hereunder shall be entitled to recover the cost of such action so incurred, including without limitation, reasonable attorney's fees. The SHERIFF's obligation under this section shall be to the extent permitted by law.

11.10 Other Contracts and Third-Party Beneficiaries. The parties agree that the SHERIFF shall take all reasonable steps necessary to assist in obtaining third party reimbursement. The parties agree that they have not entered into this Agreement for the benefit of any third person or persons, and it is their express intention that the Agreement is intended to be for their respective benefit only and not for the benefit of others who might otherwise be deemed to constitute third-party beneficiaries hereof.

11.11 Severability. In the event any provision of this Agreement is held to be unenforceable for any reason, the unenforceability thereof shall not affect the remainder of the

Agreement, which shall remain in full force and effect and enforceable in accordance with its terms.

11.12 Force Majeure. Neither party shall be held responsible for any delay or failure in performance (other than payment obligations) to the extent that such delay or failure is caused, without limitation, by strikes, inmate disturbances, acts of public enemy, fire, flood, earthquakes, hurricanes, failure of transportation, explosion, war, embargo, government regulation, civil or military authority, acts of God, acts or omissions of carriers or other similar causes beyond its control.

11.13 Trial Duty. In the event PHS' personnel are required to devote time with regard to litigation or threatened litigation by or on behalf of the SHERIFF this shall be part of their service time pursuant to this agreement. PHS will make every effort to fill the position, which would be vacant due to such court or trial appearance requirements and PHS will not be assessed a penalty for any related unfilled hours.

11.14 Default. Unless PHS' performance is specifically exempted by this Agreement, the SHERIFF shall be entitled to a credit or reimbursement for any cost the SHERIFF incurs for any medical services required to be performed by PHS when and to the extent that PHS shall fail to perform and a thirty (30) day cure period has passed. The credit or reimbursement provided for in this section shall not be deemed to be the sole remedy of the SHERIFF and the SHERIFF are otherwise entitled to seek all other lawful remedies the SHERIFF are entitled to under this Agreement, including any and all damages stemming from the failure of PHS to pay as is required under this Agreement.

11.15 Funding Sources. The parties acknowledge that performance of this Agreement and payment for medical service to PHS pursuant to this Agreement is predicated on the continued annual appropriations by the Board of County Commissioners of Leon County to the SHERIFF with specific funds allocated to meet the medical needs of the inmates in the JAIL and the SHERIFF's ability to perform under this Agreement.

11.16 Permits and License. PHS acknowledges that it will maintain all relevant permits and licenses required to perform the services required by this Agreement. This will include, but not be limited to licenses and permits for radiology and pharmacy. PHS shall manage and maintain all licenses and permits in accordance with Section 7.2 of the Florida Model Jail Standards. PHS shall ensure that all individuals or entities performing the health care services required under this Agreement, including its employees, agents, assignees, subcontractors or independent contractors shall be appropriately licensed, registered or certified as required by applicable law. PHS shall immediately notify the SHERIFF of any revocation, suspension, termination, expiration, restrictions, etc., of any required license, registration or certification of any individual or entity to perform the services herein specified.

11.17 Effect of This Agreement. This Agreement constitutes the complete understanding between the parties with respect to the terms and conditions set forth herein and supersede all previous written or oral agreements and representations. The terms and conditions of this Agreement shall control over any terms and conditions in any solicitation, request for proposal, proposal, purchase order, acknowledgment, or other written form. This Agreement may be

modified only in writing that expressly references this Agreement and is executed by the parties hereto.

11.18 Liaison. The SHERIFF or his designee (so designated in writing by the SHERIFF) shall be the liaison with PHS. PHS shall also designate a liaison who shall work with the SHERIFF to administer the Agreement by reviewing Agreement compliance. Representatives of PHS and the SHERIFF shall meet on a regular basis to discuss, evaluate, and act upon any operational or contractual issues regarding the provisions provided herein.

11.19 Authority. Each party hereto expressly represents and warrants that the person executing this Agreement is the legal, valid and binding representative of each party.

11.20 Exhibits. Exhibits "A", "B", and "C", and the information contained in the three (3) ring binder dated August 23, 2002 and identified as PHS Proposal Number: 782002, are included as attachments and are heretofore made a part of this Agreement.

11.21 Audit: The SHERIFF reserves the right to audit all records relating to this Agreement.

IN WITNESS WHEREOF, the parties have executed this Agreement in their official capacities with legal authority to do so.

SHERIFF:

By: _____
Larry Campbell

Date: 10/11/02

ATTEST:

By: Karen Allen

Date: 10/11/02

PRISON HEALTH SERVICES, INC.

By: _____

Title: RVP/COO

Date: 10/7/02

ATTEST:

By: _____
Officer of Corporation

Date: 10/7/02

Exhibit A

Prison Health Services Inc.
Staffing Plan for
Leon County Detention Facility

POSITION	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Hrs/ Wk	FTE
DAY SHIFT									
Health Services Administrator	8	8	8	8	8			40	1.0
Medical Director	8	8	8	8	8			40	1.0
Director of Nurses	8	8	8	8	8			40	1.0
RN Physicals	8	8	8	8	8			40	1.0
RN Infirmary	8	8	8	8	8	8	8	56	1.4
LPN Pharmacy Tech.	8	8	8	8	8			40	1.0
LPN	8	8	8	8	8	8	8	56	1.4
LPN	8	8	8	8	8	8	8	56	1.4
Certified Nurse Assistant	8	8	8	8	8			40	1.0
Administrative Assistant	8	8	8	8	8			40	1.0
Medical Records Supervisor	8	8	8	8	8			40	1.0
Medical Records Clerk	8	8	8	8	8			40	1.0
EMT/LPN	8	8	8	8	8	8	8	56	1.4
Dentist	8	8						16	0.4
Dental Assistant	8	8						16	0.4
Psychiatrist	4		4		4			12	0.3
Mental Health Professional	8	8	8	8	8	4		44	1.1
LPN Sick Call Triage Nurse	8	8	8	8	8			40	1.0
EVENING SHIFT									
ARNP/PA	4	4	4	4	4			20	0.5
RN Infirmary	8	8	8	8	8	8	8	56	1.4
LPN	8	8	8	8	8	8	8	56	1.4
LPN	8	8	8	8	8	8	8	56	1.4
EMT/LPN	8	8	8	8	8	8	8	56	1.4
Medical Records Clerk	8	8	8	8	8			40	1.0
NIGHT SHIFT									
RN Infirmary	8	8	8	8	8	8	8	56	1.4
LPN	8	8	8	8	8	8	8	56	1.4
EMT/LPN	8	8	8	8	8	8	8	56	1.4
TOTAL HOURS/FTE per week								**1164**	**29.10**

Summary

POSITION	Hrs/ Wk	FTE
Medical Director	40	1.00
Psychiatrist	12	0.30
PA/ARNP	20	0.50
Dentist	16	0.40
Dental Assistant	16	0.40
Health Services Administrator	40	1.00
Director of Nurses	40	1.00
Administrative Assistant	40	1.00
Medical Records Supervisor	40	1.00
Medical Records Clerk	80	2.00
Mental Health Professional	44	1.10
RN	208	5.20
LPN	360	9.00
LPN/EMT	168	4.20
Certified Nurse Assistant	40	1.00
TOTAL HOURS/FTE per week	**1,164**	**29.10**

Exhibit B

Attachment # 2
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Prison Health Services, Inc.
Salary Rates
Leon County

Position	Hourly Rate	Fringe Rate per Hour	Total Rate per Hour
Physician	$70.00	$9.95	$79.95
Psychiatrist	100.00	11.41	111.41
ARNP	35.00	3.99	38.99
Dentist	55.00	6.27	61.27
Dental Asst.	15.00	1.71	16.71
Mental Health Professional	21.00	4.02	25.02
HSA	31.25	5.51	36.76
DON	27.88	5.12	33.00
Administrative Assistant	13.50	3.49	16.99
Medical Records Supervisor	14.42	3.58	18.00
Medical Records Clerk	11.00	3.20	14.20
RN	22.00	4.19	26.19
LPN	15.50	3.40	18.90
LPN/Paramedic/RMA/CMA	15.50	3.40	18.90
CNA/EMT	14.00	3.55	17.55

Exhibit C

Protease Inhibitors

Listing as of September 1, 2002*

Leon County Sheriff's Office

Protease Inhibitors
Agenerase (amprenavir)
Crixivan (indinavir)
Fortovase (saquinavir-sgc)
Invirase (saquinavir-hgc)
Kaletra (lopinavir/ritonavir)
Norvir (ritonavir)
Viracept (nelfinavir)

*** This listing is of approved Protease Inhibitors as of September 1, 2002 if any Protease Inhibitors are approved in accordance with CDC criteria during the term of this agreement those medications shall be considered for addition to this listing on an annual contract basis.**

FIRST AMENDMENT
TO
INMATE HEALTH SERVICES AGREEMENT

This First Amendment to the Inmate Health Services Agreement is hereby executed by and between Prison Health Services, Inc. (hereinafter referred to as "PHS") and Larry Campbell, as SHERIFF of Leon County, Florida, a County Constitutional Officer of the State of Florida, for the Leon County SHERIFF'S Office (hereinafter referred to as "SHERIFF"), both of whom are also referred to herein, collectively, as the "Parties."

WHEREAS, PHS and SHERIFF executed an Inmate Health Services Agreement (hereinafter referred to as "Main Agreement"), the effective date of which was October 1, 2002, whereby PHS assumed the responsibility for the provision of certain healthcare services, which were to be provided to the inmates at the correctional facility specified in said Main Agreement; and

WHEREAS, PHS and SHERIFF hereby amend said Main Agreement, along with all previous Addenda and Amendments thereto; and

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the receipt and sufficiency of which are hereby acknowledged, it is hereby agreed, as follows:

1. This First Amendment shall take effect as of October 01, 2004;

2. For the period of October 01, 2004 through September 30, 2005 of said Main Agreement, the annual aggregate cap on off-site medical specialty care (Section 1.5 of said Main Agreement), shall be increased by 6.9%, which is proportionate to the increase in the base compensation (Section 1.9 of said Main Agreement). As such, the annual aggregate cap of off-site medical-specialty care for the period October 01, 2004 through September 30, 2005 shall increase from $500,000 to $534,923;

3. For the period of October 01, 2004 through September 30, 2005 the base compensation shall be $3,547,620 (Section 9.1 of Main Agreement), and the per diem rate of $2.25 shall be applied to the monthly base compensation for each inmate in excess of the average monthly base population (beyond a 24 hour period) of 1,200 (Section 9.2 of Main Agreement);

4. The Parties shall have a quarterly reconciliation of the annual aggregate cap based upon actual paid claims as follows:
   --1st Quarter (3/12th's of the aggregate cap)
   --2nd Quarter (6/12th's of the aggregate cap)
   --3rd Quarter (9/12th's of the aggregate cap)
   --4th Quarter (Full aggregate limit)

PHS shall provide quarterly documentation to support paid claims, and the SHERIFF shall apply adjustments to the subsequent month's invoice in the form of a credit to the SHERIFF or additional reimbursement to PHS, based upon such quarterly documentation. PHS and SHERIFF shall perform a reconciliation of the annual cap no later than 120 days after September 30, 2005. This reconciliation shall be final, with the SHERIFF having no further obligation for the costs of off-site medical specialty care incurred during said period of October 01, 2004 through September 30, 2005 (Section 1.5 of Main Agreement).

5. In all other respects, the terms and conditions of said Main Agreement and all Addenda and Amendments thereto, all of which as amended therein and hereby, shall continue unchanged and in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this First Amendment to Inmate Health Services Agreement, in their official capacities, with legal authority to do so.

SHERIFF:

By: Larry Campbell
Larry Campbell

Date: 9-23-04

PRISON HEALTH SERVICES, INC.

By: Rodney D Holleman

Title: Group Vice President

Date: 9/27/04

ATTEST:

By: Karen Allen

Date: 9-23-04

ATTEST:

By: President
Officer of Corporation

Date: 9-28-04

Attachment # 3
Page 1 of 80

Review of the Impact of the Mentally Ill Population on County Jails

February 2005

Legislative Committee on Intergovernmental Relations

FLORIDA LEGISLATIVE COMMITTEE ON INTERGOVERNMENTAL RELATIONS

(As of January 2005)

LEGISLATIVE MEMBERS

Rep. Adam Hasner, Chair
Delray Beach
Sen. Dennis Jones, Vice-Chair
Seminole
Sen. Lee Constantine
Altamonte Springs
Sen. Ron Klein
Delray Beach
Sen. Evelyn Lynn
Ormond Beach
Rep. Priscilla Talyor
Riviera Beach
Rep. Trudi Williams
Fort Myers
Rep. Phillip Brutus
North Miami

GUBERNATORIAL APPOINTEES

Comm. Robert Bullard
Highlands County
Comm. Lou Ann Palmer
Sarasota
Tom Greer, School Board Member
Osceola County
Comm. Kenneth Welch
Pinellas County
Councilwoman Carmela Starace
Royal Palm Beach
Secretary Thaddeus Cohen
Tallahassee
1 Member to be Appointed

WHAT IS THE LCIR?

The Legislative Committee on Intergovernmental Relations is a legislative entity that facilitates the development of intergovernmental policies and practices. The Florida LCIR strives to improve coordination and cooperation among state agencies, local governments, and the federal government.

WHAT ISSUES HAVE BEEN ADDRESSED BY THE LCIR?

The LCIR completes several projects annually, including the Local Government Financial Information Handbook (prepared with the assistance of the Florida Department of Revenue), a compilation of the salaries of county constitutional officers and elected school district officials, and a report on state mandates affecting municipal and county governments. In addition, the LCIR has addressed the following issues:

- Municipal Incorporations and Annexation
- Impact Fees
- Jail and Article V Costs
- Local Govt. Financial Emergencies
- State, Regional, and Local Planning
- Constitutional Initiatives & Referenda
- State Revenue Sharing Programs
- Special District Accountability
- Double Taxation
- Local Government Debt
- Urban Infill & Infrastructure Capacity
- Federal Funds to Florida, Federal/State Relations

If you would like additional copies of this report or if you have comments or questions pertaining to the information contained herein, please contact the LCIR at (850) 488-9627 or Suncom 278-9627. We welcome your input or suggestions. Our mailing address is:

Florida LCIR
c/o House Office Building
Tallahassee, FL 32399-1300
Homepage: http://fcn.state.fl.us/lcir

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List of Tables and Attachments

Executive Summary

Mentally ill individuals who are incarcerated are increasingly a national concern. Estimates of the percentage of the jail population suffering from mental illness are being reported as between 7 percent and 16 percent. In Florida, the incidence may be even higher in some locations. Once incarcerated, the mentally ill create legal liabilities and treatment challenges.

Sheriffs and Boards of County Commissions are becoming increasingly concerned about the number of mentally ill persons in the county jail population. Concerns encompass the increased costs of housing, medicating the mentally ill in jail and even the appropriateness of their incarceration. The availability and linkages with community mental health resources are central to these concerns.

This review describes and examines the scope of the problem, emphasizing changes that have occurred in the last five years. Developments in the mental health commitment process known as the Baker Act are described. The organization and funding of community mental health services in Florida are examined. Significant previous studies on the impact of the mentally ill population on county jails are presented. Jail diversion programs in Florida are depicted. Results of a survey developed for this review of Sheriffs and jail personnel in conjunction with recent studies of Orange and Sarasota Counties, as well as a recent Miami-Dade County Grand Jury Report, are summarized to give perspectives from the field. Federal level developments directed at funding programs to positively impact the mentally ill offender treatment are described. Finally, major findings of the review are summarized and LCIR recommendations are presented.

1. General Background

Much progress has been made in the treatment of the mentally ill, including identification and treatment of the frequently co-occurring disorder of substance abuse. Evidenced based practices (practices supported by outcomes based research), other best practices and emerging practices have been identified to divert the mentally ill from the judicial system and treat them appropriately in the community.

Despite advances in treatment options, deinstitutionalization of the mentally ill, starting in the 1960s in Florida, has created challenges for Florida's developing community mental health system. Chronically scarce community mental health services include appropriate case management, housing, medication, transportation, life and work skill training and other services for the mentally ill. Without adequate resources to maintain the mentally ill in the community, they are often left without treatment and continue to deteriorate. This often results in their coming in contact with law enforcement, and the "criminalization" of the underserved mentally ill.

Once in jail, the mentally ill are subject to the protections of the Eighth Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment. This translates to a requirement to provide basic mental health care to inmates such as systematic screening and evaluation, treatment including making medications available, and suicide prevention. Safeguarding these judicially recognized rights of the mentally ill inmate compounds cost factors for jails

Community mental health services have largely supplanted mental health institutions

nationally and in Florida. The catalyst for change occurred with the onset of the deinstitutionalization, which gathered momentum in the early sixties with the passage of the federal Community Mental Health Centers Act and subsequent Community Mental Health Services Act.

The Florida legislature enacted the Baker Act in 1971 to establish rights and responsibilities for involuntary commitment to community and state mental health facilities. Funding arrangements had changed a year earlier, in 1970, to require local entities provide a 25% match to receive federal mental health funds. The funding of community mental health services was centralized with the state in what is now the Florida Department of Children and Families, although the locus of funding decisions has been decentralized to administrative districts under various public/private arrangements. In the 1980s, direct federal funding of community mental health was reduced with the introduction of community mental health block grants. Medicaid started in 1965 as a federal/state program that provides medical care for low-income individuals, became an increasingly important source of funding for community mental health services. Currently, Medicaid funds over 50% of community mental health services.

Community housing, combined with community mental health services, has been an area of concern in Florida since the early days of deinstitutionalization. The consensus opinion is that Florida, as well as all other states, lack adequate resources in these areas to meet demand. In recent years, Florida has been attempting to better allocate state funds to lessen disparities among Florida counties. However, there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.

2. Funding

Adult community mental health services in Florida are primarily funded by federal programs. Medicaid, with its 41% state matching requirement, is by far the largest, accounting for a federal/state total of $444.5 million appropriated in FY 2003-2004. The Community Mental Health Services Block Grant is the next federal program in size and importance, providing federal funds in the $20-$30 million range. State revenue provided $221.2 million in FY 2003-2004 to pay for adult community mental health services not paid for by federal or local sources. Local sources provide approximately $100 million in cash and in-kind matching funds.

Adults involuntarily committed under the Baker Act are funded by the state. Medications provided to residents in Baker Act receiving facilities or state mental hospitals are also paid for by state funds. Counties are responsible for the costs of medications and mental health services provided in the jails.

3. Relevant Studies

Several studies have been conducted in recent years that focus on Florida's jail system and the mentally ill. The findings and recommendations of these studies are remarkably consistent with national studies. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time in jail than their non-mentally ill counterparts once incarcerated. Professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation,

treatment, and support services frequently are not provided to this population in a prompt manner. When a mentally ill person comes in contact with police, too often they are arrested and taken to jail rather than to a more appropriate community mental health facility. Mentally-ill jail inmates frequently have a co-occurring drug abuse problem.

Several themes emerge from the various studies reviewed in this report.

- First, deinstitutionalization has resulted in greater numbers of the mentally ill coming in contact with the judicial system.
- Second, it is less expensive and probably more appropriate to divert mentally ill misdemeanants to the community mental health system.
- Third, good communication and working relationships between community health professionals and those in the judicial system, especially at the county jails, help achieve appropriate and timely treatment for the mentally ill.
- Finally, adult community health systems necessary for the treatment of diverted individuals in the least restrictive and cost efficient manner include case management, supervised residential treatment, and day treatment programs.

Recommendations of these studies include

- Improving communication and coordination between personnel in the judicial system and personnel in the community mental health system to facilitate diversions of the mentally-ill from jail and coordinate aftercare of the mentally ill upon release from jail.
- Diversion programs are viewed as especially desirable. Diversion programs include pre-arrest programs and post-arrest programs.
- The preferred pre-arrest diversion program is the police-based Crisis Intervention Team.
- The post-arrest program commonly mentioned is the drug court that allows for a reduced sentence or dropped charge after successful completion of court-ordered community mental health treatment.
- Community based Assertive Community Treatment teams are favored for aftercare of severely mentally ill individuals upon release from jail.

4. Jail Diversion Programs in Florida

Jail diversion and aftercare programs in Florida are modeled on national standards. Pre-arrest Crisis Intervention Teams (CITs) are designed to divert the mentally ill to appropriate community mental health treatment upon contact with police in lieu of arrest. CITs are composed of volunteer police officers who have received at least 40 hours of specialized training. In Florida, standardized training modules are in development that includes customized components such as cultural diversity and mental health issues. Reporting standards that include outcome information are also in development by the coalition of mental health professionals and CIT practitioners who help develop the training modules and will be shared with the DCF mental health program office. CITs currently operate in five urban regions of Florida.

Post-arrest mental health courts are designed to reduce jail time and obtain treatment for the mentally ill. Mental health courts for non-violent misdemeanor violators exist in six counties in Florida. The mental health court was pioneered in Broward County. The Broward County mental health court continues as a national role model with the addition of a low level felony offender mental health court.

Post-incarceration jail linkage programs are designed to place a mentally ill inmate, upon release, in the care of the local community mental health system. Florida Assertive Community Treatment (FACT) teams are designed to provide 24 hours a day, 7 days a week, comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. There are 30 FACT teams in 22 Florida counties treating over 2,000 individuals.

Long-term supervised housing is a key component in all mental health diversion programs in Florida. Mental health residential facilities, assisted living facilities and adult family-care homes provide such housing. However, the demand for such housing far exceeds their capacity in Florida.

5. Local Perspectives

As a part of this review, each Sheriff's office was sent a survey by the LCIR in the fall of 2004. The survey was designed to elicit information from the experts in the Sheriff's office on the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. Special emphasis was placed on how things have changed in the last five years. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. Responses were received from twenty Sheriff's offices from small, medium and large counties. The information provided through this survey is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The Sheriff is responsible for providing Baker Act transportation. The reported costs per Baker Act trip was higher in the rural areas such as Taylor County ($125/ trip), served by remote Baker Act receiving facilities, than in more urban areas such as Palm Beach County ($20/trip) with nearby receiving facilities. The reported yearly number of Baker Act trips ranged from 7 in Nassau County to 1,620 in Polk County.

In general, FACT teams are well regarded by survey respondents. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

Most respondents indicated that mentally ill inmates pose a greater problem now than five years ago. The most frequently reported challenge faced in managing inmates with mental illness was their housing once in jail. The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice but to mix the mentally ill with the general population. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent problem cited along with the lack of training for jail staff in dealing with the mentally ill.

Most, but not all, respondents reported that the overall effectiveness of their jail's services for inmates with mental illness has declined in the last five years. Jurisdictions that reported improved services attributed the improvements to outsourcing of mental health services, increases in mental health

staffing levels or improvements in communication with the local community mental health system.

The biggest barriers identified by respondents to delivering more effective mental health services were reported as being the costs or availability of medications, the shortage or availability of community mental health resources, funding, and communication. Conversely, respondents' recommendations to alleviate the impact of the mentally ill on their county jails included, in order of decreasing frequency: (1) increase community health resources, (2) add secure community mental health facilities or state mental health hospital beds, (3) establish some form of diversion program, and (4) add more affordable or assisted living or long-term care beds in their communities. Additional comments amplify these concerns and recommendations.

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April. Respondents' comments on the potential impact of these changes were mixed, ranging from no opinion, to no change, to a possible slight increase in mental health inmates. Several respondents viewed the changes favorably. State funding was seen as a missing ingredient to potential benefits of the recent Baker Act changes by one respondent and echoed in the Miami-Dade County Grand Jury Report.

6. Significant Pending Federal Issues

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S.1194, became Public Law No: 108-414 on October 30, 2004. This law directs that grants be used to create or expand mental health courts or other court-based programs, in-jail transitional services, specialized mental health training and services, and support intergovernmental cooperation between State and local governments with respect to the mentally ill offender. The law authorizes $50 million in FY 2005 and such sums as necessary for fiscal years 2006 through 2009.

The Miami-Dade County Grand Jury Report filed January 11, 2005 reported that the Miami Criminal Mental Health project was awarded a one million dollar grant from the federal Substance Abuse and Mental Health Administration to expand the existing pre and post jail diversion programs. The pre-arrest program follows the CIT model. The post-arrest program diverts eligible misdemeanor defendants to community mental treatment within 24 to 48 hours of arrest. This project includes a comprehensive case management program that addresses transition and housing issues as well as substance abuse.

7. Major Findings

The major findings of the review are summarized below:

- Community mental health services in Florida are funded by federal, state, and local-matching funds. Local-matching funds are generally required by statute to draw down federal grants. Medicaid does not have a local-matching requirement and is now the major funding source in the federal-state-local mix.
- Complying with legal requirements regarding screening and treatment of the mentally ill inmates adds to the cost factors for jails.
- Increases in the costs of anti-psychotic medication as well as services provided

to the mentally ill in jail are funded by the county.

- Larger jails provide more elaborate treatment and in-jail housing options. Still the resources within the criminal justice system necessary to cope with the mentally ill are inadequate.
- Inadequate public funding for community mental health services is widely viewed as negatively impacting the treatment of the mentally ill in Florida communities, limits the ability of the criminal justice system to divert the mentally ill from jail to more appropriate community mental health settings, and limits aftercare of the mentally ill upon release from jail. The funding of recent changes to the Baker Act allowing involuntary outpatient placement is seen as important, if not essential, to its implementation.
- The most prevalent pre-booking diversion program in Florida is the police-based Crisis Intervention Team (CIT). CITs exist in various police departments in large urban counties. DCF mental health program staff indicates that training modules and reporting practices are still under development.
- Post-booking diversion programs, such as mental health courts must include a negotiation that reduces penalties or waives penalties pending successful completion. Such mental health courts exists in five Florida counties
- Post-incarceration programs rely on linkages to effective community treatment programs. The program of choice at this time is the Florida Assertive Community Treatment (FACT) team. Currently, there are 30 operational FACT teams in Florida, with others in the process of being activated. Essentially, FACT teams treat the most severely mentally ill individuals around the clock with diverse and specialized mental health and vocational services, assisted living and intensive team case management.

8. Recommendations

The LCIR approved the following recommendations:

- Monitor Florida's utilization of federal grant monies made available by P.L 108-414 and other federal sources and support future funding.
- Encourage and support the Department of Children and Families in developing the training and reporting components of the police-based Crisis Intervention Team programs and other pre-arrest diversion programs as deemed appropriate by local community mental health systems.
- Continue to fund and expand the Florida Assertive Community Treatment teams and encourage routine communication with the judicial system, especially appropriate jail personnel.
- Continue to utilize federal matching dollars to the extent possible for the delivery of community mental health case management and services.
- Encourage the Department of Children and Families to work with the federal government to promote that more flexible spending requirements be attached to federal funding sources, coupled with outcome reporting requirements.

INTRODUCTION

Sheriffs and Boards of County Commissions are becoming increasingly concerned about the number of mentally ill persons in the county jail population. Concerns encompass the increased costs of housing, medicating the mentally ill in jail and even the appropriateness of their incarceration. The availability and linkages with community mental health resources are central to these concerns.

Mental health services historically have been underfunded in Florida, as in most states. Inadequate funding results in scarce resources for jails to augment their ability to manage and divert individuals with mental health problems that come in contact with law enforcement and the judiciary. Many community mental health resources that do exist rely on Medicaid for over half the funding. However, Federal law does not allow for Medicaid funding for adults in jail.

This review describes and examines the scope of the problem, emphasizing changes that have occurred in the last five years. Developments in the mental health commitment process known as the Baker Act are described. The organization and funding of community mental health services in Florida are examined. Significant previous studies on the impact of the mentally ill population on county jails are presented. Jail diversion programs in Florida are depicted. Results of a survey developed for this review of Sheriffs and jail personnel in conjunction with recent studies of Orange and Sarasota Counties, as well as a recent Miami-Dade County Grand Jury Report, are summarized to give perspectives from the field. Federal level developments directed at funding programs to positively impact the mentally ill offender treatment are described. Finally, major findings of the review are summarized and recommendations are presented.

PART I

Scope of the Problem

People with mental illness frequently come in contact with law enforcement officers when they exhibit disruptive behaviors in public places. Often, the mentally ill individual is arrested on a minor violation and taken to the county jail. This response is time consuming, costly and usually not in the best interest of the judicial system or the individual.

According to the U.S. Department of Justice, Bureau of Justice Statistics, in 1998, 16% of the jail population in the United States reported a mental condition or a recent overnight stay in a mental hospital.[1] Multiplying this percentage by the Bureau of Justice Statistics jail population for 2002 translates to 106,476 jail inmates nationwide and 21,120 jail inmates in Florida with mental conditions. In Florida, in some counties, the percentage of mentally ill jail inmates likely is even higher. The Broward County Jail reports it dispenses anti-psychotic drugs to approximately 1,100 of 5,000 inmates on a daily basis—22% of their jail population.[2] Once incarcerated, the mentally ill create legal liabilities and treatment challenges. These mentally ill jail inmates cost more to house and generally stay in jail longer. It is perceived as a growing and costly problem at the county jail level.

Much progress has been made in the treatment of the mentally ill, including identification and treatment of the frequently co-occurring disorder of substance abuse. Evidence based practices (practices supported by outcomes based research), other best practices and emerging practices have been identified to divert the mentally ill from the judicial system and treat them appropriately in the community.

Despite advances in treatment options, deinstitutionalization of the mentally ill, starting in the 1960s in Florida, has created challenges for Florida's developing community mental health system. Chronically scarce community mental health services include appropriate case management, housing, medication, transportation, life and work skill training and other services for the mentally ill. Without adequate resources to maintain the mentally ill in the community, they are often left without treatment and continue to deteriorate. This often results in their coming in contact with law enforcement and the "criminalization" of the underserved mentally ill.

Once in jail, the mentally ill are subject to the protections of the Eighth Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment. This translates to a requirement to provide basic mental health care to inmates such as systematic screening and evaluation, treatment including making medications available, and suicide prevention.[3] Safeguarding these judicially recognized rights of the mentally ill inmate compounds cost factors for jails.

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[1] Paula M. Ditton, U. S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report: Mental Health and Treatment of Inmates and Probationers (July 1999, NCJ 174463).

[2] Carol Marbin Miller and Wanda J. DeMarzo, "Health firm for jail can't dispense medicine," The Miami Herald. December 3, 2004.

[3] New Freedom Commission on Mental Health, *Subcommittee on Criminal Justice: Background Paper.* DHHS Pub. No. SMA-04-3880. Rockville, MD: 2004 at 13.

PART II

Developments in Mental Health Commitment Process: The Baker Act

A. Florida's Baker Act

Every state has laws pertaining to involuntary examination and treatment for those individuals with mental illness. Florida's mental health commitment laws are found in "The Florida Mental Health Act," alternatively referred to as the "Baker Act."[4] This compendium of civil commitment laws was named after its sponsor, Maxine Baker, a Representative from Miami, who successfully ushered her bill through passage in 1971. Since that time, the Baker Act has undergone dozens of revisions. Most recently, the Baker Act was amended to include provisions for involuntary outpatient examination and commitment.[5]

B. Civil Commitment Prior to the Baker Act

Prior to the Baker Act, procedures for getting a person committed for psychiatric evaluation and treatment lacked consistency and notions of due process. Signed affidavits submitted to a judge by three people were all that was needed to have a person committed to a state psychiatric hospital. The period of commitment could be indeterminate, and no judicial review after the initial commitment was required. Poor people were delivered to local law enforcement for holding until hospitalization could be arranged. Access to the outside world was restricted. Abuse of the process was to be expected, as there were virtually no checks and balances or monitoring. Mentally ill people were being warehoused, sometimes indefinitely. In 1955, almost 560,000 were residing in state mental hospitals.

The ease with which a person could be deprived of his or her liberty through this process received a considerable amount of attention throughout the nation in the 1960's and 1970's. Many states legislated a movement away from institutionalizing mentally ill persons to a more community based treatment environment. The individual freedom of the mentally ill was perhaps an outgrowth or corollary of the larger civil rights movement of that era. When advocating for passage of her bill, Representative Baker reportedly said in speaking of the mentally ill, "In the name of mental health, we deprive them of their most precious possession – liberty."[6]

C. Deinstitutionalization

Thus, the Baker Act was consistent with laws being passed in other states at a time when mental health experts, policy makers and advocates were searching for ways to deal with the mentally ill without resorting to widespread institutionalization. By 2002, the number of people with severe mental illnesses in public mental hospitals nationwide had fallen to 70,000.[7] In fact, by mid 2001, there were 1,334,255 persons in the custody of federal and state prisons, and 631,240

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[4] These laws are found in Part I, ss. 394.451-4789, Fla. Stat.
[5] See section 394.4655, Fla. Stat. (2004).
[6] "History of the Baker Act – Its Development and Intent," State of Florida Department of Children and Families Mental Health Program Office, May 2002 at 1, retrieved at http://www.dcf.state.fl.us/mentalhealth/laws/histba.pdf .
[7] The Sentencing Project, "Mentally Ill Offenders in the Criminal Justice System: An Analysis and Prescription," January 2002 at 3.

inmates in the custody of local jails.[8] In Florida, it was reported that 2,671 patients were in state mental hospitals in 1999, while county jails housed 5,300 inmates with mental illnesses and state prisons housed 6,800 such inmates.[9]

D. Criminalization

For reasons still being analyzed and debated, the deinstitutionalization of the mentally ill resulted, to a certain extent, in the criminalization of the mentally ill. While patients were being released from psychiatric hospitals, too few receiving facilities with adequate treatment plans, personnel and funding were established. Community facilities, and families, were ill-equipped to contend with the rapid outflow of hundreds of thousands of mentally ill persons. The lack of community willingness or expertise to provide a therapeutic environment for the mentally ill, funding limitations, and procedural challenges to involuntary commitment process all contributed to the unmet needs faced by the mentally ill.

Unmonitored, untreated mentally ill people with little or no support system in place quickly posed challenges for law enforcement agencies across the nation. Despite their lack of mental health training, police officers and sheriff's deputies are generally the first ones called to respond to a conflict in which one or more parties is mentally ill. The numbers of calls received by law enforcement officers to respond to situations involving a mentally ill person are significant.[10] For this reason, many mental health professionals and law enforcement agencies have joined forces to formulate training and programs to enable law enforcement agencies to be better prepared to deal with the mentally ill. These programs do not seek to substitute law enforcement activity for mental health treatment, but rather strive to ensure more appropriate police behavior when responding to the mentally ill. Such training and programs better serve the safety needs of the officer, the patient and the public.

E. Movement Toward Civil Outpatient Commitment

Balancing the interests of these groups continued to be a challenge. In 1996, concerns regarding patients' rights in commitment proceedings lead to significant revision of the Baker Act. Procedural and substantive changes were made to ensure more individual control by the mentally ill person throughout the commitment process and significantly improved patients' rights and access.[11] The Act was also amended to require all facilities receiving patients under the Baker Act to submit a copy of any court order, report by law enforcement, or certificate executed by an authorized clinician that serves as the basis for involuntary commitment to the Agency for Health

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[8] Allen J. Beck, Jennifer C. Karberg and Paige M. Harrison, Bureau of Justice Statistics Bulletin: Prison and Jail Inmates at Midyear 2001, April 2002 at1., retrieved at http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim01.pdf .
[9] *Id.*, citing Debbie Salamone Wickham, "Society Criminalizes Their Mental Illness," Orlando Sentinel, October 31, 1999.
[10] Melissa Reuland, "A Guide to Implementing Police-Based Diversion Programs for People with Mental Illness," Technical Assistance and Policy Analysis Center for Jail Diversion, January 2004, p. 2.
[11] Chapter Law 96-169, L.O.F. 1996 (HB 903).

care Administration.[12] The agency must use these and other documents to prepare annual reports analyzing the data.[13]

Until the legislative changes made in 2004, the Baker Act provided for the involuntary inpatient commitment of an individual if certain criteria were met. The statute provided in part:

> 394.467 **Involuntary placement.--**
> (1) CRITERIA.--A person may be involuntarily placed for treatment upon a finding of the court by clear and convincing evidence that:
> (a) He or she is mentally ill and because of his or her mental illness:
> 1.a. He or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment; or
> b. He or she is unable to determine for himself or herself whether placement is necessary; and
> 2.a. He or she is manifestly incapable of surviving alone or with the help of willing and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or
> b. There is substantial likelihood that in the near future he or she will inflict serious bodily harm on himself or herself or another person, as evidenced by recent behavior causing, attempting, or threatening such harm; and
> (b) All available less restrictive treatment alternatives which would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

The fact that the Baker Act provided only for involuntary inpatient commitment has generated debate for many years. Other states have grappled with the public perception that mandated treatment would make the citizenry safer. New York passed one of the more controversial laws allowing court ordered outpatient treatment after a woman, Kendra Webdale, was pushed onto the subway tracks by a man whose psychiatric condition would deteriorate whenever he was released from inpatient treatment. In response to the death of Ms. Webdale and other similar events, New York passed "Kendra's Law" in 1999.[14] The law in New York and similar laws in other states are challenged from time to time as being too restrictive of the liberty and privacy rights of the mentally ill, but thus far, the laws remain valid.

In Florida, efforts to include provisions for involuntary outpatient commitment have been made in the last several legislative sessions. In the 2004 legislative session, discussion of the balancing of law enforcement, patients and the public's interests continued, and resulted in the passage of Chapter Law 2004-385. This bill was strongly advocated for by law enforcement

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[12] *Id.*, section 16; Section 394.463(2)(a)1-3, Fla. Stat. (2003).
[13] The responsibility for preparing the annual reports has been redirected to the Policy and Services Research Data Center at the Louis de la Parte Florida Mental Health Institute at the University of South Florida. The annual reports are available online at http://bakeract.fmhi.usf.edu .
[14] N.Y. Mental Hyg. Law § 9.60(c) (McKinney 1999).

agencies. Among other things, this bill amended the Baker Act to clarify that section 394.467, Fla. Stat., applies to *inpatient* commitment. The most significant change to the Baker Act, however, created a process for involuntary *outpatient* commitment. Florida joined in a trend that several states, including New York and California, have followed in recent years. The following language was added to the Baker Act:

> **394.4655 Involuntary outpatient placement.--**
> (1) CRITERIA FOR INVOLUNTARY OUTPATIENT PLACEMENT.--A person may be ordered to involuntary outpatient placement upon a finding of the court that by clear and convincing evidence:
> (a) The person is 18 years of age or older;
> (b) The person has a mental illness;
> (c) The person is unlikely to survive safely in the community without supervision, based on a clinical determination;
> (d) The person has a history of lack of compliance with treatment for mental illness;
> (e) The person has:
> 1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or
> 2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months;
> (f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and either he or she has refused voluntary placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of placement for treatment or he or she is unable to determine for himself or herself whether placement is necessary;
> (g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient placement in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1);
> (h) It is likely that the person will benefit from involuntary outpatient placement; and
> (i) All available, less restrictive alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.

This language is similar to statutes in some, but not all, states that allow for involuntary outpatient commitment without a finding of dangerousness on the part of the patient to be

committed.[15] The standard for involuntary outpatient commitment is less stringent than that required for involuntary inpatient commitment.

The impact of these amendments may be difficult to predict or measure in the future. The reason for this is that a petition for involuntary outpatient commitment can be filed only if the services necessary for the individual's treatment are available. If the services in the proposed treatment plan "are not available in the patient's local community to respond to the person's individual needs, the petition may not be filed."[16] Thus, although the process for securing involuntary outpatient commitment is now available, there is no indication that the resources for treatment are available as required by statute prior to filing a petition.

Annual reports are prepared by the Louis de la Parte Mental Health Institute for the Agency for Health Care Administration. The reports analyze data contained in forms submitted to the Institute (as required by statute) such as the source of the commitment petition, type of evidence provided (i.e., harm, neglect or both), timeliness of the forms being submitted, and demographics of those being examined or committed under the Act. It is anticipated that similar statistics will be kept for those patients subject to the new involuntary outpatient commitment provisions. This information may shed a little light on the availability of resources, as well as any trends that may arise under the new law.

[15] See Attachment 1 for a state by state summary of standards for assisted outpatient treatment (court ordered outpatient treatment).
[16] Section 394.4655(3), Fla. Stat. (2004).

Part III

Organization of Community Mental Health Services in Florida

A. Institutions

Florida has three public mental health hospitals. The Florida State Hospital at Chattahoochee opened in 1876 as a publicly funded institution for the mentally ill. MacClenny (Northeast State Hospital) and Pembroke Pines (South Florida State Hospital) opened by the late 1950s.[17] G. Pierce Wood Memorial Hospital, which opened in 1947, closed in February 2002. These remaining three facilities serve civil Baker Act (Ch.394, F.S.) and forensic (Ch. 916, F.S.) patients. In addition, two facilities (the North Florida Evaluation and Treatment Center and the South Florida Evaluation and Treatment Center) are run by the Florida Department of Corrections and only treat forensic patients. The bed capacity of all five facilities totals 2,385 and serves a Florida population that has grown from approximately 5 million in 1960 to projected population of 17.76 million in 2005.

Table 1 depicts the number of beds dedicated to civilian patients, male forensic patients, female forensic patients, and civil/forensic step-down patients. Forensic step-down patients are those who do not require a secure institutional setting.

Table I
Bed Capacity by Type of Patient and Florida State Mental Health Treatment Facility

Facility	Civil Beds	Male Forensic Beds	Female Forensic Beds	Civil/Forensic Step-Down Beds
Florida State Hospital	220	417	83	271
Northeast Florida State Hospital	481			72
North Florida Evaluation and Treatment Center		216		
South Florida Evaluation and Treatment Center		176	24	
Atlantic Shores Healthcare, Inc./South Florida State Hospital	280			45
Total Beds:	981	809	107	388

[17] Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006* (Jan. 1, 2004) at 30.

Trends for both involuntary civil Baker Act admissions and forensic admissions to Florida State Mental Health Treatment Facilities are tracked by DCF. Between January and November of 2004 the reported monthly average waiting time for a civil admission ranged from 3 days to 38 days, depending on the facility. The civil admission waiting list, for the same time frame, ranged from 3 people to 21 people, again, depending on the facility. On the forensic side of the equation, the average wait for all facilities combined between January and November of 2004 ranged between 19.3 days and 36.3 days. According to DCF, a spike in the forensic waiting list occurred in September and October was attributed to hurricane activity in Florida. The forensic waiting list peaked in late September with a total of 74 of 150 patients waiting for more than 15 days—the legal requirement. Yearly forensic commitments have increased 22% to 1,257 from fiscal year ending June 30, 2000 to fiscal year ending June 30, 2004.

Advances in mental health medications have allowed for the possibility of community treatment.[18] The shift from institutional placement to community treatment that occurred in the 1960s and 1970s—deinstitutionalization—was viewed as a more humane, less restrictive, and more cost effective alternative for the mentally ill. The unintended consequences of deinstitutionalization have been the chronic shortage of essential community mental health support services that too often lead to contact of the mentally ill with the criminal justice system. The result is what many call the criminalization of the underserved mentally ill population. In fact, studies from around the country suggest that between 6 and 16% of all jail inmates have a severe mental illness.[19]

B. Community Services

Small guidance clinics for the mentally ill funded through county governments, United Way or other voluntary sources began to appear in late 1950s. Also during that time period, the Florida State Board of Health provided visiting public health nurses who would check on individuals discharged from state mental health treatment facilities. However, no organized, comprehensive, publicly funded community mental health services system existed in Florida.[20]

Deinstitutionalization started to take hold nationally in the 1960s and several key events affected Florida's development and growth in providing community mental health services. First, at the federal level, the Federal Community Mental Health Centers Act passed in 1963, providing federal funding to states for developing community-based systems of care, primarily by providing the means for the construction of comprehensive community mental health centers.[21] This legislation marked a major shift at the federal level to encourage the treatment of the mentally ill locally, rather than in large isolated state hospitals. This was followed two years later, in 1965, by the passage of the federal Community Mental Health Services Act which helped fund the actual mental health services delivered at comprehensive community mental health centers.[22]

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[18] *Id.* at 30.
[19] Borum, R. & Rand, M. (1999). *Mental Health Diagnostic and Treatment Services in Florida's Jails.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 41.
[20] Florida Department of Children and Families, *supra* note 17 at 30.
[21] Florida Department of Children and Families, *supra* note 17 at 30.
[22] Florida Department of Children and Families, *supra* note 17 at 30.

As federal funds were made available, Florida enacted laws to develop a community mental health structure. In 1970, Florida established local contribution requirements to be eligible to receive federal funds now distributed through the state rather than directly to the community mental health centers or clinics from the federal government. This local match was 25%, including some allowable in-kind contributions.[23] At the same time, Florida created Mental Health Boards, composed of local citizens appointed by county commissions, for service areas defined by the state (Division of Mental Health). All community mental health services were provided through board contracts with private providers.[24]

As previously described, the Baker Act was enacted in 1971 to provide due process in involuntary admission proceedings and set uniform criteria for persons being admitted to state treatment facilities.

The Division of Mental Health was reorganized in 1975 within the newly formed Department of Health and Rehabilitative Services (HRS), as the Alcohol, Drug Abuse and Mental Health (ADM) Program Office. HRS was configured as a "matrix" organization to facilitate direct interaction among the program planning, administrative support, and district operations components without the hierarchal protocols of traditional organizations. The ADM program office performed planning and programmatic oversight, with the day-to-day mental health services coordination occurring at the district operations level. District mental health specialists reported to one of eleven district administrators, who reported to the deputy secretary for operations, who reported to the secretary of HRS. The actual contracting of mental health services remained with the mental health boards at the local level.[25]

In 1984, major revisions were made to the Baker Act. Mental health boards were replaced with planning councils. Planning councils retained the local mental health planning and evaluation role. However, authority to actually allocate resources through contract was shifted to the HRS district offices, with the condition that the contracts be consistent with the district mental health services plan.[26]

Also in the mid-1980s, federal mental health funding declined with the advent of block grants. Medicaid[27] was used increasingly to leverage federal funding of mental health services at the community level. Two Medicaid components, in particular, have been used for Medicaid Community Mental Health Services Rehabilitation and Targeted Case Management Programs. Currently, Medicaid funding accounts for over half of all state expenditures for the publicly-funded community mental health system in Florida.[28]

Upon the dissolution of HRS in 1996, the ADM program office was placed in the newly created Department of Children and Families, and the 11 districts were increased to 15. Subsequently,

[23] The Community Mental Health Act, Part IV of Ch. 394, F.S.
[24] Florida Department of Children and Families, *supra* note 17 at 31-32.
[25] Florida Department of Children and Families, *supra* note 17 at 32.
[26] Florida Department of Children and Families, *supra* note 17 at 32.
[27] Medicaid, enacted in 1965, is a state and federal partnership that provides health care to low-income, categorically eligible individuals.
[28] Florida Department of Children and Families, *supra* note 17 at 32-33.

districts 5 and 6, and Sarasota County and Desoto County from district 8 were merged into the Suncoast district, resulting in 14 districts currently. In 2003, the ADM program offices, now known as the Mental Health and Substance Abuse Offices, were given line authority over district programs and state mental health treatment facilities. The mental health program director was given direct control over the program's budget and contracts for services. A Deputy Secretary for Substance Abuse and Mental Health, with direct accountability to the Secretary, was created. Finally, the Florida Substance Abuse and Mental Health Corporation was formed as an independent entity with three major functions: (1) review the mental health and drug abuse service system; (2) assess the need for services, manpower and resources; and (3) provide a forum for direct advocacy with policymakers.[29] These changes in mental health services administration were designed to improve accountability and facilitate an equitable allocation of available resources.

C. Community Resources

Community resources to provide housing for those released from public mental health institutions were developed during the 1960s as deinstitutionalization was implemented. By the 1980s, Florida was one of the few states to attempt an organized response to deinstitutionalization through creation and funding of assisted living facilities that featured: (1) case management, (2) a continuum of residential care, and (3) day treatment programs. These programs were phased out in favor of less restrictive assisted living arrangements combined with community mental health services. Currently, community mental health services are delivered in a variety of settings, including short-term crisis stabilization units, residential facilities, individual homes, community support services, clubhouses, drop-in centers and other community settings.

According to a recent report of the Senate Appropriations Committee,[30] funds for mental health are usually appropriated in total, and then allocated by DCF by service district. However, over time, some districts accumulated larger shares of the statewide appropriations. In FY1997-98, a law was enacted in an attempt to address inequities in district funding: s. 394.908, F.S., provides that any funds allocated for community mental health by the state above the FY 1996-97 base be allocated by service district. Current funding levels in each district are supplemented by 75% of whatever increase above the FY 1996-97 base is contained in the current general appropriations act as enacted into law, taking into account the levels of the current target population. A pro rata share distribution is made that ensures districts below the statewide average funding level per person in each target population of "persons in need" receive funding necessary to achieve equity. The remaining 25% of the increase is allocated by service district strictly based on target populations without regard to current funding levels. Disparities in funding levels among service districts are expected to steadily decrease with each funding cycle.

Despite bureaucratic changes and more equitable funding measures, community resources to assist the mentally ill have never met the demand and remain in short supply. According to the

[29] Florida Department of Children and Families, *supra* note 17 at 33-34.
[30] The Florida Senate, Committee on Appropriations Subcommittee on Health and Human Services (2004), Interim Monitor Project 2004-318: Analysis of Mental Health, Drug Abuse and Child Protection Funding Distribution by District.

state FY2003-04 Community Mental Health Services Block Grant application submitted by the Florida Department of Children and Families (DCF), there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.[31]

D. Summary of Part III

Community mental health services have largely supplanted mental health institutions nationally and in Florida. The catalyst for change occurred with the onset of the deinstitutionalization, which gathered momentum in the early sixties with the passage of the federal Community Mental Health Centers Act and subsequent Community Mental Health Services Act.

Florida established the Baker Act in 1971 to establish rights and responsibilities for involuntary commitment to community and state mental health facilities. Funding arrangements were changed a year earlier, in 1970, to require local entities to provide a 25% match to receive federal mental health funds. The funding of community mental health services was centralized with the state in what is now the Florida Department of Children and Families, although the locus of funding decisions has been decentralized to administrative districts under various public/private arrangements. In the 1980s, direct federal funding of community mental health was reduced with the introduction of community mental health block grants. Medicaid started in 1965 as a federal/state program that provides medical care for low-income individuals, became an increasingly important source of funding for community mental health services. Currently, Medicaid funds over 50% of community mental health services.

Community housing, combined with community mental health services, has been an area of concern in Florida since the early days of deinstitutionalization. The consensus opinion is that Florida, as well as all other states, lack adequate resources in these areas to meet demand. In recent years, Florida has been attempting to better allocate state funds to lessen disparities among Florida counties. However, there is a need for: (1) more initiatives to assure appropriate, safe housing; (2) more resources to provide supported living environments; (3) more free or low-cost medications for individuals without benefits; and (4) low-cost or free transportation.

[31] Florida application for FY 2003-2004 Community Mental Health Services Block Grant at 32.

Part IV

Florida Funding of Community Mental Health Services

Community mental health services in Florida are funded by federal, state, and local-matching funds. Federal monies account for most of the funding, especially Medicaid, and, to a lesser degree, a variety of other federal programs including the Community Mental Health Services Block Grant. Medicaid does not have a local-matching requirement. Medicaid, which is about 59% federal dollars and 41% state general revenue, is now the major federal funding source in the federal-state-local mix. Once a mentally ill person enters the correctional facility, Medicaid will not cover anything. State appropriations are next in importance, providing matching funds for Medicaid and funding Baker Act services. Local-matching funds, required by Florida law, provide an important but smaller source of funding than federal and state government. Local-matching funds are generally required by statute to draw down federal grant funds. "Local-matching funds" is defined by statute and means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other source.[32]

The adult population targeted for community mental health services is defined in Florida law.[33] Adults in mental health crisis, older adults in crisis, adults and older adults with serious and persistent mental illness (SPMI), and adults with forensic involvements are included in the adult community mental health side of the design of services. The Florida Department of Children and Families (DCF) have specific criteria defining these groups. The SPMI is considered the benchmark group by DCF. The prevalence of SPMI is calculated at 2.4% of the adult population, using estimates based on recommendations of the federal Center for Mental Health Services. The SPMI rate used to calculate the subgroup eligible for public mental health services is 1.3%. This is a median or midpoint, based on a range of prevalence, reported by the National Alliance for the Mentally Ill.[34]

DCF is responsible for identifying and coordinating programs and services for the mentally ill, primarily through contractual arrangements with local providers. The Agency for Health Care Administration (AHCA) is the State of Florida entity responsible for administering the approved Florida Medicaid Plan. AHCA is the fiduciary agent responsible for dispersing Medicaid funds use to provide approved services for eligible—primarily low income—individuals.

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[32] s. 394.67(14), F.S.
[33] s. 394.9082(7)(b), F.S.
[34] Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006*, 47-48 (Jan. 1, 2004).

A. Figures and Tables

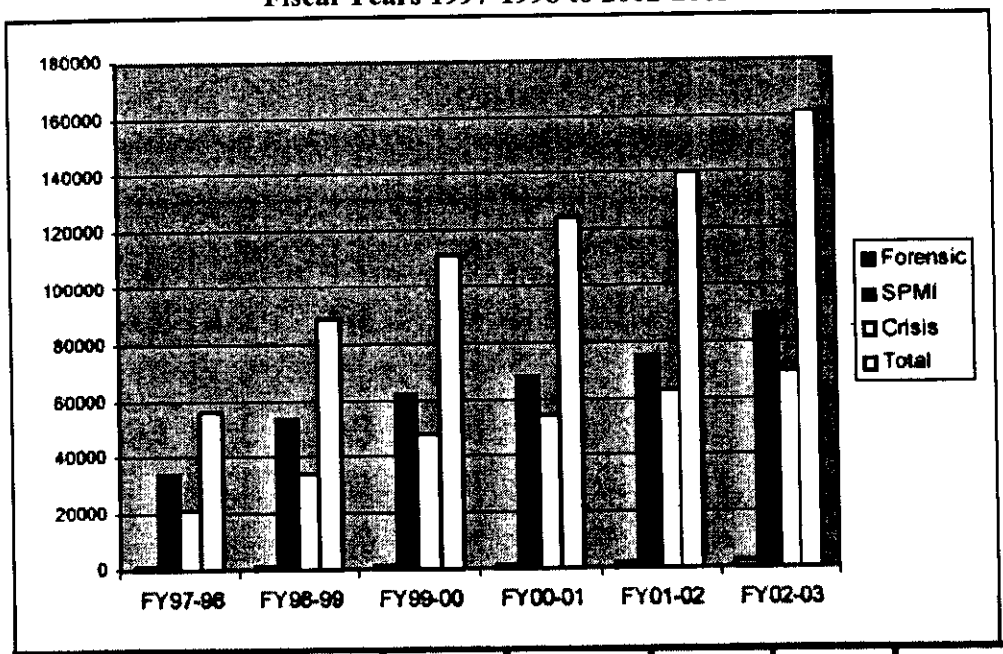
Table 2 depicts both the adult serious and persistent mental illness (SPMI) population and the adult SPMI population eligible for public mental health services for the five year period 1999-2003. The official April 1 Florida population estimates are provided by the Bureau of Economic and Business Research (BEBR) located at the University of Florida. The SPMI population in Florida has matched the percentage increase in total Florida population of 11.4% from 1999 to 2003, even though some yearly increases in percentage of adults to the general population differ.

Table 2
Growth in Severely and Persistently Mentally Ill (SPMI) in Florida, 1999-2003

Year (Apr. 1)	1999	2000	2001	2002	2003
Tot. Pop.	15,322,040	15,982,824	16,331,739	16674608	17,071,508
Percent Change: Total		4.3%	2.2%	2.1%	2.4%
Less than 18	3,363,091	3,646,450	3,646,340	3,720,208	3,750,347
Adult Pop.	11,958,949	12,336,374	12,685,399	12,954,400	13,321,161
Percent Change: Adults		3.2%	2.8%	2.1%	2.8%
SPMI @ 2.4%	287,015	296,073	304,450	310,906	319,708
SPMI @ 1.3%	155,466	160,373	164,910	168,407	173,175

Table 3 was taken from the DCF *Mental Health and Substance Abuse Services Plan: 2003-2006 (January 1, 2004)*. It depicts the growth in the three adult target populations served from fiscal years ending June 30, 1998 through 2003. Comparing Table 2 with Table 3, with the population calculations based on April 1 estimates, two patterns emerge. First, a greater percentage of the adult public service eligible SPMI population is being served each year, increasing from 34.6% in 1999 to 51.5% in 2003. Second, there remains tremendous unmet need.

Table 3
Total Adult Target Population Individuals Served
Fiscal Years 1997-1998 to 2002-2003



Target Population	FY 1997-98	FY 1998-99	FY 1999-00	FY 2000-01	FY 2001-02	FY 2002-03
Adults with severe & persistent mental illness	34,051	53,736	62,261	68,137	75,299	89,267
Adults in mental health crisis	20,639	34,382	47,789	54,288	62,995	69,666
Adults with forensic involvement	1,119	896	1,055	1,464	1,717	2,059
Total	55,809	89,014	111,105	123,889	140,010	160,991

The funding of community mental health services, especially adult community mental health funding, is examined from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. The actual expenditures of funds may deviate by as much as 10% at the district level. Section 20.19(5)(b), F.S. grants authority to District Administrators to move 10% of their total district budget around with the Florida Department of Children and Families (DCF) Secretary's approval. State general revenue that is used to provide matching funds to pull down most, but not all, federal Medicaid funds for mental health services is included in DCF community mental health funding information. Federal Medicaid and Agency for Health Care Administration (AHCA) state funds for community mental health services are presented separately in this

section of the review. Differences between funding levels presented and the appropriation acts is due to gubernatorial vetoes of certain proviso language and line items.

Table 4 presents mental health yearly appropriations from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. Adult mental health appropriations as a percent of total mental health appropriations rose from approximately 33% in FY 2000-2001 to approximately 40% in FY 2002-2003, where it has remained through FY 2004-2005. Slightly more money was allocated to the state mental health hospitals, except in FY 2002-2003. As previously mentioned, G. Pierce Wood closed in February of 2002. The shift that occurs in funding adult mental health is due to a shift to adult community mental health services in the catchment area served by G. Pierce Wood.

Table 4

Mental Health Appropriations for State FYs 2000-2001 thru 2004-2005

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004	State FY 2004-2005
Adult Mental Health Services	$203,056,826	$233,871,635	$267,296,193	$265,759,328	$272,291,807
Percent Change: Adult Mental Health		15.2%	14.3%	-0.6%	2.5%
Sexually Violent Predator Program	$20,018,040	$23,010,119	$23,266,344	$23,336,666	$23,339,273
Percent Change: SVPP		14.9%	1.1%	0.3%	0.0%
Children's Mental Health Services	$98,917,715	$98,272,931	$96,152,947	$95,364,437	$96,807,391
Percent Change: Children's MH		-0.7%	-2.2%	-0.8%	1.5%
Mental Health State Treatment Facilities	$280,265,693	$283,366,363	$260,614,703	$287,764,037	$284,350,084
Percent Change: MHSTF		1.1%	-8.0%	10.4%	-1.2%
Program Management and Compliance	$9,452,596	$9,484,475	$10,028,074	$9,547,745	$8,560,198
Percent Change: PM & C		0.3%	5.7%	-4.8%	-10.3%
Total Appropriation	$611,710,870	$648,005,523	$657,358,261	$681,772,213	$685,348,753
Percent Change: Total Appropriation		**5.9%**	**1.4%**	**3.7%**	**0.5%**

The year-to-year growth in funding of adult mental health services has been relatively flat since the fiscal year ending on June 30, 2003. Except for the transition fiscal years when G. Pierce Wood closed, funding for state mental health hospitals has also been flat. Children's mental health services have remained stable for the entire five year period depicted in Table 3. The Sexually Violent Predator Program received a several million dollar boost in FY 2001-2002, then remains flat. When all mental health programs are taken as a group, funding has increased 5.9% from FY 2000-2001 to 2001-2002, then 1.4%, 3.7%, and 0.5% for the subsequent year-to-year

funding comparisons. In general the nominal growth in state resources going into mental health has changed little in the past five years despite the increased number of people in need of services.

Table 5 presents adult mental health yearly appropriations from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. Community mental health services represent the largest component, followed by Baker Act services and the Indigent Drug program. Other mental health programs and services, related to the closure of G. Pierce Wood mental health hospital, appear starting in FY 2001-2002. The variations in year-to-year percent changes in funding again reflect adjustments in the adult mental health system due to the closing of G. Pierce Wood. Funds formerly used to operate G. Pierce Wood were transferred to community mental health services in the area that was served by the mental health hospital. Overall changes in funding levels for FY 2004-2005 from FY 2003-2004 was a modest 2.5%, with no change in funding for Baker Act services or the Indigent Drug program.

Table 5
Adult Mental Health Appropriations for State
FYs 2000-2001 through 2004-2005

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004	State FY 2004-2005
Community Mental Health Services	$148,239,133	$156,467,200	$193,988,075	$197,311,582	$201,295,367
Percent Change: CMHS		5.6%	24.0%	1.7%	2.0%
Baker Act Services	$49,377,706	$55,517,650	$56,099,570	$56,099,570	$56,099,570
Percent Change: Baker Act		12.4%	1.0%	0.0%	0.0%
Indigent Drug Program	$5,439,987	$7,445,203	$8,280,276	$6,780,276	$6,780,276
Percent Change: IDP		36.9%	11.2%	-18.1%	0.0%
Other Mental Health Programs/Services		$14,441,582	$8,928,272	$5,567,900	$1,722,409
Total Appropriation	$203,056,826	$233,871,635	$267,296,193	$265,759,328	$272,291,807
Percent Change: Tot. Appr.		15.2%	14.3%	-0.6%	2.5%

Table 6 depicts the Florida Department of Children and Families funding sources for adult mental health programs from fiscal year ending June 30, 2001 until fiscal year ending June 30, 2005. General revenue consistently represents approximately 80% of the funding and includes some general revenue used to match Medicaid. A variety of other trust funds contribute 20%.

Table 6
Florida Department of Children and Families
Adult Mental Health Programs
Funding History from State FY 2000-2001 through FY 2004-2005

	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
	Budget	State Funds	State Funds	State Funds	State Funds
Adult Mental Health					
General Revenue	162,401,605	184,018,916	212,498,742	210,044,427	218,494,080
Alcohol/DrugAbuse/ Men Hlth TF	15,110,914	19,480,914	19,480,914	20,480,914	19,480,914
Tobacco Settlement TF	8,692,633	8,892,633	8,872,633	8,872,633	8,872,633
Federal Grants TF	12,620,639	16,248,137	22,212,869	22,130,319	13,350,584
Grants and Donations TF	1,099,807	1,099,807	1,099,807	1,099,807	1,099,807
Operations and Maint TF	3,131,228	4,131,228	3,131,228	3,131,228	3,300,000
Welfare TF					7,693,789
TOTAL	***203,056,826***	***233,871,635***	***267,296,193***	***265,759,328***	***272,291,807***

Table 7 depicts the Medicaid funding of adult community health services for fiscal years ending June 30, 2000 through 2004. Note that some Medicaid funding is imbedded in the DCF budget. The first two rows of Table 6 provide detail to the third row total Medicaid adult mental health funding, separate from the DCF budget, and excluding Medicaid pharmacy funds. The overall growth of the complete Agency for Health Care Administration (AHCA) Medicaid budget for adult community mental health has fluctuated between 7.14% and 8.96% after June 30, 2001. Not surprisingly, costs of Medicaid adult mental health anti-psychotic drugs have increased the most since June 30, 2000—fluctuating between 18.4% and 24.12% yearly. This increase in the costs of anti-psychotic drugs provides insight to rising medication costs in similar drugs not paid by Medicaid provided in jails, Baker Act receiving facilities and Florida prisons. The total Medicaid contribution to community adult mental health that excludes Medicaid funds contained in the DCF budget topped $400 million in fiscal year ending June 30, 2004.

Table 7
Medicaid Funding of Adult Community Mental Health Services

	1999-00	2000-01	2001-02	2002-03	2003-04
Total Community Mental Health Services-Adults	68,218,029	55,280,940	54,375,019	54,489,787	58,463,887
Total Case Management Svcs-Adult Mental Health	24,862,193	29,446,683	31,735,604	32,684,674	28,176,533
Total Medicaid Adult Mental Health, Separate from DCF Budget, Excluding Drugs	93,080,222	84,727,623	86,110,623	87,174,461	86,640,420
Medicaid Funded Case Management Services in DCF Budget	8,942,749	13,472,581	0	1,254,631	0
Medicaid Funded Prepaid Mental Health Plan in DCF Budget*	5,083,992	4,536,778	5,208,353	5,715,478	44,514,994
Total Medicaid Adult Mental Health Anti-Psychotic Drugs Separate from DCF Budget	41,273,695	51,229,521	62,776,480	74,353,730	88,777,533
Percent Change from Previous Year		24.12%	22.54%	18.44%	19.40%
Total Medicaid Adult Mental Health All other drugs Separate from DCF Budget	89,597,806	95,578,210	107,659,478	118,423,413	137,957,468
Percent Change from Previous Year		6.67%	12.64%	10.00%	16.50%
Total AHCA Medicaid Adult Mental Health Budget	317,031,945	316,262,977	342,657,204	367,126,065	400,015,841
Percent Change from Previous Year		-0.24%	8.35%	7.14%	8.96%

* A major prepaid mental health managed care initiative is reflected in FY 2003-04.

Table 8 examines the combined AHCA and DCF appropriations for fiscal years ending June 30, 2001 through 2004. The Medicaid and other state and federal programs funded through DCF are separated into the "Total DCF Appropriation without Medicaid" row and the "Total Medicaid Appropriation" row. The bottom row represents the "Total Medicaid Appropriation" as a percentage of the combined appropriation—between 59% and 66.8%--in the years examined. With all the budget adjustments, Medicaid accounted for $444,530,835 in payments for community adult mental health in fiscal year ending June 30, 2004. The shift downward from fiscal year 2003 to 2004 for total DCF appropriation without Medicaid is attributed to the increase in the appropriation for Medicaid for community mental health services rehabilitation and especially targeted case management for those same years. This table does not include local government matching funds or funds from other state agencies that may provide ancillary support to adult community mental health programs. Table 8 illustrates that Florida utilizes the allowable federal match under Medicaid to fund the majority of adult community mental health services. Also, Table 8 shows that funding of adult community mental services has increased to $665.8 million in state fiscal year 2000-2001, representing a 28.2% increase from state fiscal year 2000-2001 to 2003-2004.

Table 8
Adult Mental Health Appropriations for State FYs 2000-2001 thru 2003-2004

	State FY 2000-2001	State FY 2001-2002	State FY 2002-2003	State FY 2003-2004
Total DCF Appropriation w/o Medicaid	$185,047,467	$228,663,282	$260,326,084	$221,244,334
Percent Change: Tot. DCF Appr.		23.6%	13.8%	-15.0%
Percent Change: 2001 to 2004				19.6%
Total Medicaid Appropriation	$334,272,336	$347,865,557	$374,096,174	$444,530,835
Percent Change: Tot. Medicaid Appr.		4.1%	7.5%	18.8%
Percent Change: 2001 to 2004				33.0%
Medicaid as Percent of Tot. Adult M.H. Appr.	64.4%	60.3%	59.0%	66.8%
Grand Total of Adult Mental Health Appropriations	$519,319,803			$665,775,169
Percent Change: 2001 to 2004				28.2%

Table 9 presents a summary of the local match by district for fiscal year ending June 30, 2002. All districts met or exceeded their local-matching requirements pursuant to s. 394.76, F.S. State Mental Health Program Office staff indicated that not all local entities eligible to participate in the match met their 25% share in certain counties, with the difference made up by local entities in other counties including county governments. As mentioned previously "local-matching funds" means funds received from governing bodies of local government, including city commissions, county commissions, district school boards, special tax districts, private hospital funds, private gifts, both individual and corporate, and bequests and funds received from community drives or any other source. The Suncoast District (composed of districts 5 and 6 and part of district 8 which includes Pasco, Pinellas, Hillsborough and Manatee, Sarasota, and Desoto Counties) exactly met their local matching requirement as did District 10 (Broward County) and District 12 (Palm Beach County).

Table 9
Summary of Local Match by District for FY ending June 30, 2002

Districts	Total Match Required In Contracts	Actual Match Provided All Counties/District	Total Cash Match	Total In-Kind Match
01	$3,545,581	$4,661,196	$3,312,851	$1,348,347
02	$2,732,728	$3,400,709	$2,650,987	$749,722
03	$2,770,836	$4,766,507	$4,766,507	$0
04	$7,230,685	$9,810,837	$9,649,918	$160,919
SC	$13,785,942	$13,785,942	$13,785,942	$0
07	$7,035,399	$21,620,809	$18,075,811	$3,544,998
08	$5,073,671	$8,052,260	$5,593,589	$2,458,671
09	$4,520,483	$13,681,783	$11,162,354	$2,519,429
10	$5,455,190	$5,455,190	$5,455,190	$0
11	$9,002,460	$10,756,950	$10,756,950	$0
12	$2,849,761	$2,849,761	$2,836,038	$13,723
13	$3,128,658	$8,246,711	$8,227,766	$18,945
14	$1,620,618	$2,036,514	$1,582,533	$453,981
15	$2,399,490	$2,401,605	$2,013,877	$387,728
Total	$71,151,502	$109,526,776	$97,870,313	$11,656,463

Source: Florida Department of Children and Families, *Mental Health and Substance Abuse Services Plan: 2003-2006*, 188 (Jan. 1, 2004).
Note: SC means Suncoast.

Table 10 presents a DCF funding history summary by activity from fiscal year ending June 30, 2002 until fiscal year ending June 30, 2005. Overall, emergency stabilization is the costliest activity in publicly funded adult mental health. Emergency stabilization funding has increased modestly each year after a one year jump in FY 2002-2003. Residential care is the next most costly activity. Its funding has varied widely from year to year. Community support service funding has gradually increased after a bump in funding in FY 2002-2003. Florida Assertive Community Treatment (FACT) teams provide comprehensive support services to the severely and persistently mentally ill.

Table 10
ADULT MENTAL HEALTH
FUNDING HISTORY SUMMARY BY ACTIVITY FROM FY 2001-02 THROUGH FY 2004-05

	FY 01-02	FY 02-03	FY 03-04	FY 04-05
	Total	Total	Total	Total
Adult Mental Health				
Emergency Stabilization	64,428,054	76,180,980	76,324,063	79,048,939
Residential Care	36,084,578	56,721,677	66,193,337	55,855,517
Case Management	11,844,707	17,994,406	17,758,821	19,948,712
Outpatient Services	66,960,907	38,277,146	35,201,627	39,432,898
Community Suppt. Services	12,376,274	23,987,156	27,470,715	30,425,653
FACT Teams	22,392,639	37,631,820	35,517,239	35,834,055
TOTAL *	214,087,159	250,793,185	258,465,802	260,545,774

**** Differences between activity totals and appropriation totals are due to funds being in either EOG reserve, in Approved Operating Budget "control," or a combination of both.***

B. Summary of Part IV

Adult community mental health services in Florida are primarily funded by federal programs. Medicaid, with its 41% state matching requirement, is by far the largest, accounting for a federal/state total of $444.5 million appropriated in FY 2003-2004. The Community Mental Health Services Block Grant is the next federal program in size and importance, providing federal funds in the $20-$30 million range. State revenue provided $221.2 million in FY 2003-2004 to pay for adult community mental health services not paid for by federal or local sources. Local sources provide approximately $100 million in cash and in-kind matching funds.

Adults involuntarily committed under the Baker Act are funded by the state. Medications provided to residents in Baker Act receiving facilities or state mental hospitals are also paid for by state funds. Counties are responsible for the costs of medications and mental health services provided in the jails.

PART V

Significant Previous Studies on the Impact of the Mentally Ill Population on County Jails

Since deinstitutionalization of the mentally ill began many researchers have attempted to assess the impact of the mentally ill on jails. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time than their non-mentally ill counterparts there once incarcerated. Recent studies have focused on attempts to ameliorate the impact on jails while appropriately treating the mentally ill. This section provides an overview of some of the more significant studies conducted in recent years that apply to Florida's judicial and community mental health systems.

The Senate Committee on Children, Family and Seniors produced two reports: 1) a 1998 report on the role of county courts under the Forensic Client Services Act, and 2) a 1999 report on defining publicly funded mental health and substance abuse services and priority population groups. During this same period of time, the Louis de la Parte Florida Mental Health Institute published three Florida-based studies: 1) on jail diversion, 2) increasing court jurisdiction and supervision over misdemeanor offenders with mental illness, and 3) mental health diagnostic and treatment services in Florida jails. The final study reviewed is a National Association of Counties study on ending the cycle of recidivism. These studies provide a foundation upon which recent developments in Florida's treatment of mentally ill persons that come in contact with the judicial system may be analyzed.

A. Senate Report on the Role of the County Courts under the Forensic Client Services Act

In 1998, the Florida Senate Committee on Children, Families and Seniors reviewed the role of the County Courts under Ch. 916, F.S., the Forensic Client Services Act.[35] A survey was conducted of chief judges, state attorneys, public defenders, jail administrators, community mental health providers, and the Department of Children and Family Services district forensic coordinators. The purpose of the survey was to determine the problems and reasons for the recycling of persons with suspected or diagnosed mental illness who are arrested for or convicted of a misdemeanor. Information collected included the number arrested, the number who had their misdemeanor charges dropped, and the number receiving voluntary or involuntary treatment under the Baker Act. A review of pertinent literature, a site visit to the Fifteenth Judicial Circuit (Palm Beach County), and discussions with national forensic consultants were part of this effort.[36]

The report found that the Baker Act contains the provision for law enforcement officers to transport persons who are involved in minor criminal behavior to the nearest receiving facility for an involuntary psychiatric examination. The report also found that professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation, treatment, and support services frequently are not provided to this population in a prompt manner. In fact, transporting to receiving facilities does not always

[35] The Florida Senate, Committee on Children, Families and Seniors (October 1998), Interim Project Report 98-06: *Role of the County Courts Under Chapter 916, F.S.: Responding to Persons with Mental Illness who Commit Misdemeanors.*
[36] *Id.* at 1-2.

occur as many of these persons with mental health problems are taken to county jails. Data specifying the number or percentage of these persons who are taken to Baker Act receiving facilities as opposed to a county detention facility was unavailable.[37]

Based on the findings of this review, Senate staff concluded that local community cooperative agreements between the criminal justice and mental health agencies are needed for diverting persons with mental illness who are arrested for a misdemeanor from the criminal justice system to the mental health system when appropriate. Because law enforcement plays a major role in this diversion, it is necessary to improve training programs for law enforcement officers in identifying mental illness and to assist them with difficult mental health cases. Other strategies are needed in the area of information sharing among pertinent community entities; referring misdemeanants for after care services upon release from jail and from Baker Act receiving facilities; and providing intensive case management services. It was also recommended that increasing judicial supervision of misdemeanants with serious mental health problems, the extent and quality of in-jail mental health services, and the effectiveness of the specialized mental health court in Broward County be reviewed.[38]

B. The Louis de la Parte Florida Mental Health Institute Studies

Four studies were published in 1999 by the Louis de la Parte Mental Health Institute in response to the provisions in ch. 99-396, L.O.F. Randy Borum, an Associate Professor at the Institute, was the principle investigator and author. Three of these studies are reviewed in this report. Section 18 of the chapter law resulted in *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report.*[39] Three connected studies published together and prefaced by an Executive Summary address sections 19-21 of the chapter law. They are titled *Misdemeanor Offenders with Mental Illness in Florida: Examining Police Response, Court Jurisdiction, and Jail Mental Health Services*[40]; *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness*[41]; and *Mental Health Diagnostic and Treatment Services in Florida's Jails.*[42]

As summarized in the House Final Bill Analysis of Ch. 99-396, L.O.F.:

> Section 18 - Directs the Department of Children and Family Services to enter into cooperative agreements and develop strategies and community alternatives

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[37] *Id.* at 1-2.
[38] *Id.* at 1.
[39] Borum, R. (1999). *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida.
[40] Borum, R. (1999). *Misdemeanor Offenders with Mental Illness in Florida: Examining Police Response, Court Jurisdiction, and Jail Mental Health Services.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 1-17.
[41] Borum, R. (1999). *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 18-40.
[42] Borum, R. & Rand, M. (1999). *Mental Health Diagnostic and Treatment Services in Florida's Jails.* Department of Mental Health Law & Policy, Louis de la Parte Florida Mental Health Institute, University of South Florida, Tampa, Florida at 41-56.

in each service district for diverting from the criminal justice system to the civil Baker Act system persons with mental illness who are arrested for a misdemeanor. Each district's strategies are to be developed through written cooperative agreements between the department, the judicial and criminal justice systems, and the local mental health providers. The Louis de la Parte Florida Mental Health Institute is directed to review strategies in Florida and other states and to recommend to the Legislature those strategies that are most effective.

Section 19 - Directs the Department of Children and Family Services and Department of Law Enforcement to recommend improvements in the training curriculum and training efforts for law enforcement officers in identifying mental illness as delivered by the Criminal Justice Standards and Training Commission and the Department of Children and Family Services.

Section 20 - Directs the Department of Children and Family Services and the Louis de la Parte Florida Mental Health Institute to study the concept of increasing court jurisdiction and supervision over persons with mental illness who are arrested for or convicted of a misdemeanor to assure compliance with an approved individualized treatment or service plan.

Section 21 - Directs the Louis de la Parte Florida Mental Health Institute and district forensic coordinators to assess the provision of in-jail mental health diagnostic and treatment services and reporting to the Legislature.

Section 22 - Requires all study reports generated in Sections 18, 19, 20 & 21 to be submitted to the Legislature by December 31, 1999.

Section 23 - Directs the Louis de la Parte Florida Mental Health Institute to evaluate the effectiveness of the specialized mental health court established in Broward County to determine client and system outcomes and cost efficiencies and proposing recommendations for establishing similar special courts in other judicial circuits.

Section 24 - Provides an appropriation of $100,000 for the studies.[43]

1. The Jail Diversion Study

The first study, *Jail Diversion Strategies for Misdemeanor Offenders with Mental Illness: Preliminary Report*, provides a concise statement of the problem in the following two paragraphs:[44]

> People with severe mental illness frequently have contact with police for disruptive behavior or minor infractions that occur because they are experiencing psychiatric symptoms or social disruptions related to their disability. These police encounters frequently result in arrest, leading to large numbers of mentally ill misdemeanants being held in jails and processed through the court system. This outcome is costly and largely unproductive.

[43] House of Representatives As Further Revised by the Committee on Children & Families Final Analysis (May7, 1999) HB 2003 (formerly PCB CF 99-02; Chapter #: 99-396, Laws of Florida), 14.
[44] Borum, *supra* note 39, at 3.

> Although some people with mental illness do commit offenses for which incarceration is the most appropriate disposition, many are confined as result of arrest for minor infractions. In these cases, confinement does not alleviate, and may exacerbate, the original problem—that is, an individual with mental illness is experiencing a crisis episode that has led to inappropriate behavior. If the goal is to reduce the likelihood of future episodes of that behavior, then mental health treatment will be a more appropriate disposition than routine criminal adjudication.

Borum also reports that studies from around the country show that between 6 and 16% of all jail inmates have a severe mental illness. Compounding the problem are co-existing conditions, especially alcohol and drug abuse. Approximately 75% of mentally ill jail inmates have a co-existing alcohol or drug abuse problem.[45]

The study found that there are two actions that are sometimes confused with jail diversion. The first action confused with diversion occurs when an inmate is transferred by the jail to a forensic psychiatric facility for evaluation. The second such action occurs when a mentally ill detainee is released to the community pending trial. In both of these actions the defendant remains in the criminal justice system. To be considered a diversion program, the mentally ill inmate would have to be managed by the community mental health system.[46]

The study reports that according to the National GAINS Center, Policy Research Associates, pre-booking diversions occur at the point of contact with law enforcement officers. It is considered pre-booking because formal charges have not been made against the suspect. Pre-booking diversion programs require effective interactions between police and community mental health and substance abuse services.[47]

Post-booking diversion occurs after a charge is made and the mentally ill individual is booked into jail. It is described in the study as the most prevalent type of diversion program in the United States. These diversion programs occur either in arraignment courts or jails. In either case, a person's eligibility for diversion is negotiated between key members of the justice system and diversion program staff in concert with community-based mental health and substance abuse providers. The key members of the justice system may include prosecutors, public defenders, attorneys, and the courts. A plan of treatment is developed and offered to the defendant as an alternative to jail or as a condition of reduction in charges, regardless of any formal conviction. Individuals who accept the conditions are then linked to the agreed upon community-based services.[48]

The study found that the model pre-booking diversion program which appears most promising is the Memphis Tennessee Police Department's Crisis Intervention Team (CIT) program. The CIT is a police-based program. Police officers who are CIT members receive 40 hours of training in a variety of mental health issues. The team operates on what is commonly referred to as a

[45] Borum, *supra* note 39, at 5.
[46] Borum, *supra* note 39, at 6.
[47] Borum, *supra* note 39, at 7 in text box.
[48] Borum, *supra* note 39, at 7 in text box.

generalist-specialist model. CIT officers have regularly assigned patrol duties, the generalist part of the model, but also provide a specialized response to "mental disturbance" crisis calls, the specialist part of the model. In Memphis, the CIT officers will leave their geographically based assignments to respond to mental health related calls anywhere in the city. The CIT officers are trained to resolve the situation on the scene. Common resolutions include de-escalation of the situation, negotiation with the individual or verbal crisis intervention. In some cases the officer may contact an individual's case manager or treatment provider, provide a referral to treatment services, or transport an individual directly to the psychiatric emergency center for further evaluation. Reported benefits of the CIT approach include reductions in arrest, little or no change in staffing or organizational structure, and very little associated costs. The partnership between the Memphis Police Department and the University of Tennessee-Memphis Medical Center's Psychiatric Emergency Center is an important element in the program's effectiveness.[49]

The Charleston, South Carolina, Mobile Crisis Team (MCT) represents a model pre-booking diversion program staffed by health and mental health professionals. According to Borum, in 1987, the Medical University of South Carolina began a public-academic emergency psychiatry program to provide psychiatric emergency services to Charleston County. In this model, the team consisted entirely of mental health and health professionals who were specially trained to provide in-the-field mental health consultation and assistance, at any time. The assistance techniques were derived from emergency room-based psychiatric services. The MCT consisted of several master's level mental health clinicians, a psychiatric intern, a medical student, a chief resident, attending psychiatrist, and a project manager. Protocols for MCT interactions with police for backup were developed and face-to-face contact between police officers and MCT members at each precinct was made at the start of the program to communicate operating procedures. The resulting partnership was reported as being highly successful.[50]

The MCT program in-the-field services and consultations has three basic components, resulting in several benefits according to Borum. First, relevant historical and clinical information is obtained from the subject and any other available sources. Second, the MCT delivers on-scene intervention. Third, advice is given to police on case disposition. Several benefits of this approach are mentioned. There is an immediate connection to the mental health system. The subject's assessment and intervention is performed by specialized mental health professionals. Finally, there is a reduction of unnecessary transports.[51]

2. Increasing Court Jurisdiction and Supervision over Misdemeanor Offenders with Mental Illness

As mentioned in a previous section of this report, court-ordered treatment that commits an individual to involuntary outpatient placement has been incorporated recently into the Florida Baker Act.[52] The study, *Increasing Court Jurisdiction & Supervision over Misdemeanor Offenders with Mental Illness,* reports that at least thirty-eight states and the District of Columbia have similar involuntary outpatient placement statutory authority. Civil commitment traditionally

[49] Borum, *supra* note 39, at 8-9, 20.
[50] Borum, *supra* note 39, at 15.
[51] Borum, *supra* note 39, at 15.
[52] Ch. 2004-385, L.O.F., Section 8, creating sec. 394.4655, F.S.

has been used as the legal procedure to place an individual into involuntary hospitalization. In recent years, civil commitment laws have been expanded to provide for involuntary outpatient treatment. Several advantages may result from outpatient commitment (OPC). First, the committed individual is permitted increased autonomy in a less restrictive treatment environment. Second, the judiciary can monitor compliance. Finally, early signs of relapse or decompensation detected in the course of outpatient treatment may be more effectively treated.[53]

The study summarizes conclusions from both initial and refined studies of mandatory outpatient mental health treatment. The initial studies indicate limited positive outcomes for a substantial number of people with mental disorders. The same finding applies to individuals who have chronic conditions. The refined or second generation studies of mandatory outpatient mental health treatment are consistent in their support for "the need for intensive community-based services to prevent relapse, violent behavior and criminal recidivism/arrest among people with severe mental illness," but "less consistent in their evidence concerning the importance of the court mandate *per se*."[54]

3. Mental Health Diagnostic and Treatment Services in Florida Jails

The Florida jail mental health survey, reported in *Mental Health Diagnostic and Treatment Services in Florida's Jails*, by Randy Borum and M. Rand, resulted in the following main recommendation: "County jails and district mental health programs should forge partnerships designed to address the challenges created by the subgroup of 'revolving door' clients who cycle through both the mental health and criminal justice systems." The report acknowledges that the jails will have to take responsibility for treatment within the facility, but suggests that the local community mental health system may be helpful for case identification and discharge planning. This suggestion was presented as very important for clients who have previously been involved in the public mental health system.[55]

C. Senate Report on Defining Publicly Funded Mental Health and Substance Abuse Services and Priority Population Groups

The passage of Ch. 99-396, L.O.F. and the resulting research by the Louis de la Parte Mental Health Institute appears to have stimulated further legislative interest. In 1999, the Florida Senate Committee on Children and Families reviewed the provisions of the "Community Alcohol, Drug Abuse, and Mental Health Services Act" that related to publicly funded mental health and substance abuse services and priority population groups.[56] The report of this committee noted that according to literature reviewed, great strides have been made in the last 20 years in the diagnosis and treatment of mental illness and addictive disorders. Further, current treatment for mental illness and substance abuse can reduce or eliminate the incapacitating effects of the illness, with the additional benefit of reducing risk to the individual and the public. Now treatment can ultimately lead to recovery. There have been significant improvements in

[53] Borum, *supra* note 41, at 22-23.
[54] Borum, *supra* note 41, at 28, 32.
[55] Borum, *supra* note 42, at 52-53.
[56] The Florida Senate, Committee on Children and Families (September 1999), Interim Project Report 2000-17: Defining Publicly Funded Mental Health and Substance Abuse Services and Priority Population Groups.

medications. The effective use of services that incorporate psychosocial rehabilitation techniques such as assertive community treatment and wraparound services is known. The report also recognized the key role that individuals can play in designing and taking responsibility for their own treatment. There are several benefits of current mental health treatment that extend beyond the individual recipient. Productivity increases, other health care costs decrease, and less demand is placed on use of other public systems, such as the local criminal justice system.[57] However, at the time of this review, in 1999, the Mental Health Program Office in Florida Department of Children and Families estimated that Florida's publicly funded mental health system was meeting approximately 12 percent of the treatment needs of adults.[58]

In addition to the literature review, as part of the Senate committee review, mental health experts were consulted and 35 key stakeholders of mental health and substance abuse services were surveyed. Twenty-six stakeholders responded to the survey. Many voiced concerns about the lack of statutory guidance for serving adults with or at risk of mental health or substance abuse problems. Suggestions were offered ranging from basic definitions, to updating descriptions of services, adding services, and changing the sliding fee schedule. Among the new categories of treatment services recommended by the stakeholders were aftercare services for persons discharged from the criminal justice system.[59] Recommendations of the review were considered in SB 358 during the 2000 general legislative session. Many of the recommendations were enacted into law by ch. 2000-349, L.O.F.

Several changes made by ch. 2000-349, L.O.F. are relevant to this study. Part IV of chapter 394, F.S., was renamed "The Community Substance Abuse and Mental Health Services Act." The intent language of this Act was changed to include the criminal justice system as one of the local systems and groups to be coordinated and integrated with in all activities related to mental health treatment and prevention services provided by the Department of Children and Family Services and the Agency for Health Care Administration and their respective contract providers.[60] "Crisis services" was defined and included the phrase "at the site of the crisis by a mobile crisis response team."[61] Finally, in defining "mental health services" reference is made to assertive community treatment in recognition of this treatment mode.[62]

D. National Association of Counties Study on Ending the Cycle of Recidivism: Best Practices for Diverting Mentally Ill Individuals from County Jails

A study of best practices for diverting mentally ill individuals from county jails, published in 2003 by the National Association of Counties (NACO) emphasizes that counties should provide leadership to develop programs to divert non-violent mentally ill offenders from county jails. Three types of diversion programs are mentioned. The first approach is a pre-arrest diversion program such as a Crisis Intervention Team where specially trained police officers divert the individual at the scene of the disturbance directly to a treatment or housing facility as an

[57] *Id.*, at 3-4.
[58] *Id.*, at 2.
[59] *Id.*, at 5-7.
[60] Section 394.66(5), Fl. Stat. (2004).
[61] Section 394.67(4), Fl. Stat. (2004).
[62] Section 394.67(16)(d), Fl. Stat. (2004).

alternative to jail. The second approach occurs after mentally ill individuals have been arrested and charged with an offense. A "mental health court" offers the offender an alternative course of action that typically involves having the individual enter into treatment and case management, while the court monitors the individual through probation. The third approach is a post-incarceration transition program that links a discharged offender to community based treatment services to help ensure that they do not re-offend and re-enter the criminal justice system. A key component in sustaining a comprehensive diversion system is the availability of a long-term, supervised residential housing program for individuals with mental illness.[63]

A variety of programs have been developed around the country, tailored to local needs and social infrastructure. According to the National GAINS Center, 7% of U.S. counties (229 of 3,142 counties) have one or more jail diversion programs. These diversion programs include 88 pre-arrest type programs, 204 post-arrest type programs, with 93 being mental health courts, and 111 other/combinations or variations of models.[64] Diversion programs can improve care for the mentally ill. County costs can be reduced while improving safety within the jails.[65]

E. Summary of Part V

Several studies have been conducted in recent years that focus on Florida's jail system and the mentally ill. The findings and recommendations of these studies are remarkably consistent with national studies. All agree that the mentally ill cost more money to keep in jail than in community care and spend more time in jail than their non-mentally ill counterparts once incarcerated. Professionals in the criminal justice system believe that many persons commit minor criminal offenses because appropriate mental health evaluation, treatment, and support services frequently are not provided to this population in a prompt manner. When a mentally ill person comes in contact with police, too often they are arrested and taken to jail rather than to a more appropriate community mental health facility. Mentally-ill jail inmates frequently have a co-occurring drug abuse problem.

Several themes emerge from the various studies reviewed in this report. First, deinstitutionalization has resulted in greater numbers of the mentally ill coming in contact with the judicial system. Second, it is less expensive and probably more appropriate to divert mentally ill misdemeanants to the community mental health system. Third, good communication and working relationships between community health professionals and those in the judicial system, especially at the county jails, help achieve appropriate and timely treatment for the mentally ill. Finally, adult community health systems necessary for the treatment of diverted individuals in the least restrictive and cost efficient manner include case management, supervised residential treatment, and day treatment programs.

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[63] National Association of Counties, *Ending the Cycle of Recidivism: Best Practices for Diverting Mentally Ill Individuals from County Jails* (June 2003), at 4-5.
[64] Power Point presentation "Diverting the Mentally Ill from Jail to Treatment" by Lesley Buchan, National Association of Counties on June 24, 2004, to the Florida Association of Counties 2004 Annual Conference in Broward County, Florida, slide 26.
[65] National Association of Counties , *supra* note 63, at 5.

Recommendations of these studies include improving communication and coordination between personnel in the judicial system and personnel in the community mental health system to facilitate diversions of the mentally-ill from jail and coordinate aftercare of the mentally ill upon release from jail. Diversion programs are viewed as especially desirable. Diversion programs include pre-arrest programs and post-arrest programs. The preferred pre-arrest diversion program is the police-based Crisis Intervention Team. The post-arrest program commonly mentioned is the drug court that allows for a reduced sentence or dropped charge after successful completion of court-ordered community mental health treatment. Community based Assertive Community Treatment teams are favored for aftercare of severely mentally ill individuals upon release from jail.

PART VI

Jail Diversion Programs in Florida

Jail diversion of the mentally ill in Florida happens through pre-arrest, post-arrest, and post-incarceration programs. First, the pre-arrest diversion program, favored in recent research, and described in this report, is the "Memphis Model" Crisis Intervention Team (CIT). Next, Mental Health Courts, representing the post-arrest diversion program in Florida, are depicted. Finally, two key elements of post-incarceration jail linkage programs, comprehensive community mental health services as provided by Florida Assertive Community Treatment teams and the availability of residential treatment facilities for the mentally ill, are examined in this section of the report.

A. Pre-Arrest: the "Memphis Model" Crisis Intervention Teams (CITs) are popular in Florida.

Several progressive law enforcement agencies throughout Florida have embraced the Crisis Intervention Team (CIT)/Memphis Model. CIT is a law enforcement initiative, in collaboration with community mental health professionals including community providers and state/district mental health program office staff and the National Alliance for the Mentally Ill (NAMI). The model is based on the best practice program initiated in Memphis, Tennessee, in the 1980's, in response to a shooting incident of a mentally ill individual. The goals of CIT are to divert the mentally ill from the criminal justice system, to provide law enforcement with the tools needed to handle encounters with the mentally ill, and to ensure the delivery of proper care for the individual in crisis through a collaboration of the mental health and criminal justice systems.[66]

CIT officers volunteer to serve on the teams in each agency. Each agency has a selection process which considers the following traits of each applicant: 1) communication skills; 2) active listening skills; 3) ability to work well under pressure; 4) ability to maintain a positive attitude under stressful conditions; 5) ability to absorb verbal abuse without negative responses; and 6) ability to exercise good judgment and decision making skills. Upon selection, the CIT candidates participate in a 40 hour training conducted by mental health professionals, CIT officers, and NAMI members in their communities. The 40 hour training curriculum is minimally comprised of the following: signs and symptoms of mental illness, medications and medical conditions, substance abuse and dual diagnosis, suicide awareness and prevention, risk assessment, family and consumer perspectives, the Baker Act and Marchman Act,[67] visits to community providers and positive interaction with mentally ill individuals, crisis intervention, and community resources. The training is a combination of lectures and role playing exercises. Several communities have added topics, such as cultural diversity, post traumatic stress disorder, and

[66] Florida Department of Children and Families, Mental Health Program Office, CIT information provided by e-mail, with phone conversation follow-up.

[67] Marchman Act Involuntary Assessment - Section 397.6811, F.S. The act provides for a Petition for Involuntary Assessment for individuals believed to be impaired by substance abuse. A General Master presides at the hearing and may enter an Order for Involuntary Assessment. The court may direct the Sheriff's Department to take the patient into custody and deliver him/her to a public facility that will assess and stabilize the patient for a period not to exceed 5 days. A written assessment is sent to the court and the court may proceed with the Petition For Involuntary Treatment.

child/adolescent issues, in response to community need. An effort is underway to standardize these CIT topics/components in Florida.

Each agency develops a dispatch protocol to ensure that certified CIT officers are dispatched to calls involving a confirmed or suspected mentally ill person in crisis or when an individual specifically asks for a CIT officer. The first CIT officer on the scene assumes responsibility for the entire call, which includes dialogue with the mentally ill individual, determining the appropriate action to be taken and the necessary paperwork. Other officers on the scene provide backup.

The following communities are implementing CITs:

- Broward County--Three law enforcement agencies (Broward County Sheriffs Office, Ft. Lauderdale Police Department and Wilton Manors Police Department).
- Palm Beach County–CIT training in this county began in 2003. Twelve law enforcement agencies (Atlantis, Belle Glade, Boca Raton, Delray Beach, Lantana, Lake Worth, Palm Beach, Palm Beach Gardens, Palm Beach Sheriff's Office, Veteran's Administration Police, and West Palm Beach).
- Orlando/Orange County/Seminole County—The Central Florida CIT group began training in 2001. Thirteen agencies (Apopka, Edgewood, Eatonville, Maitland, Oakland, Ocoee, Orlando, Orange County Sheriff's Office, Seminole County Sheriff's Office, University of Central Florida Police Department, Windermere, Winter Garden, and Winter Park)
- Daytona Beach/Jacksonville
- Miami-Dade County--City of Miami and Miami Beach and 8 other police agencies

Several communities, such as Tallahassee, have initiated CIT training. There was a forum, sponsored by Eli Lilly and Central Florida CIT, in March 2004 that included many of the agencies with active CIT programs in an effort to standardize the procedures and data collection. At this point, each agency has its own method of collecting data related to CIT calls and outcomes. The data collected includes the number of arrests/diversions, number of Baker Acts/Marchman Acts, consumer injury, officer injury, and the participation of mobile crisis teams. Upon standardization, the state mental health program office will have access to the outcome data. Anecdotal information on the effectiveness of CITs has been positive. In fact, a Miami-Dade County Grand Jury Report filed on January 11, 2004 recommends more extensive CIT training for both corrections and police officers in Miami-Dade County.

B. Post-Arrest: Mental Health Courts

In 1997, Broward County pioneered Mental Health Courts for individuals with mental illnesses who have been charged with a non-violent misdemeanor offense. Currently, such Mental Health Courts are in operation in Alachua, Brevard, Broward, Lee, Marion, and Sarasota counties. In addition, a Felony Mental Health Court was established in Broward County in November 2003

to serve individuals with mental illnesses who have been charged with low level felony offenses. The purpose of these courts is to reduce jail time and obtain treatment for the mentally ill.[68]

Mental health courts involve collaboration among correctional personnel, judges, officers of the court, and community mental health providers. Typically, a mentally ill inmate is arraigned in special mental health court as soon as possible after being arrested. A community mental health treatment plan for the inmate is agreed upon by the judge, prosecutor, public defender, and community mental health provider. The inmate is released to community mental health care under the supervision of the court. Usually the judge will allow for a reduced sentence or drop the charges against the inmate upon successful completion of the court-approved treatment plan.

According to John Petrila, Chair and Professor at the Department of Mental Health Law & Policy, University of South Florida, the Broward Mental Health Court (1) appears to increase access to care compared to traditional court, (2) participants perceive court as non-coercive and fair, and (3) individuals in mental health court spend less time in jail without increased risk to public safety. He did raise some unanswered questions about the Felony Mental Health Court, including the impact of sanctions or the threat of sanctions and the assurance of access to treatment.[69]

C. Post-Incarceration Jail Linkage Programs

Jail linkage programs attempt to place an inmate, upon release from jail, in the care of the local community mental health system. The sophistication and effectiveness of linkage programs depends on the available community mental health resources and the cooperation and communication between the judicial system, especially jail personnel, and community mental health professionals. Two components that are important to providing an effective jail linkage program in Florida are described below. Comprehensive mental health services provided by Florida Assertive Community Treatment (FACT) teams is the standard recommended by the National Alliance for the Mentally Ill (NAMI). Residential treatment facilities are the other key component.

1. FACT programs

As of June 30, 2004, there were 30 operational Florida Assertive Community Treatment (FACT) teams treating 2,291 individuals with mental illness. FACT teams provide comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. FACT teams operate 24 hours a day, every day. FACT teams assume total responsibility for the treatment, rehabilitation and support of persons enrolled, with most of these services taking place outside an office setting. Funding is through general revenue and Medicaid, with availability of housing and medication enhancement funds. The Florida Department of Children and Families states that FACT teams are the Florida equivalent of the national Program of Assertive Community Treatment (PACT) teams model; an

[68]National Association of Counties, *supra* note 63, at 44.
[69] Power Point presentation by John Petrila on June 24, 2004, to the Florida Association of Counties 2004 Annual Conference in Broward County, Florida.

evidenced-based model with 39 years of proven effectiveness in areas of (1) reduction in state hospitalization, (2) reduced cost over time, and (3) increase in quality of life of persons served.[70]

FACT teams are located in the following counties: Alachua, Brevard, Broward, Charlotte, Collier, Duval (2 teams), Escambia, Hillsborough (2 teams), Lake, Lee (2teams), Leon, Manatee, Martin, Miami-Dade (2 teams), Orange, Osceola, Palm Beach, Pasco, Pinellas (3 teams), Polk (2 teams), St. Lucie, Sarasota and Volusia. One more team is expected to be operational in Miami-Dade County by June 30, 2005.
Criteria for FACT team admission is established by DCF, and includes:

1. Individuals eligible for FACT team services must have a diagnosis within one of the following categories as referenced in the American Psychiatric Association's Diagnostic and Statistical Manual-IV, 4th Edition:
    - schizophrenia and other psychotic disorders
    - mood disorders
    - anxiety disorders
    - personality disorders.
2. Additionally, individuals must meet **one** of the following three criteria:
    - demonstrate a high risk for hospital admission or readmission
    - have prolonged inpatient days, more than 90 days; or
    - have repeated crisis stabilization contacts, more than three admissions.
3. And meet at least **three** of the following six characteristics:
    - inability to consistently perform the range of practical daily living tasks required for basic adult interact ional roles in the community (e.g., maintaining personal hygiene; meeting nutritional needs; caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family or relatives)
    - inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting or child-care tasks and responsibilities)
    - inability to maintain a safe living situation (repeated evictions, loss of housing, or no housing)
    - coexisting substance use disorder of significant duration (greater than six months)
    - destructive behavior to self or others; or
    - high risk or recent history of criminal justice involvement (arrest and incarceration).[71]

[70] See http://www.dcf.state.fl.us/mentalhealth/forensic/fact.shtml
[71] See http://www.dcf.state.fl.us/mentalhealth/forensic/factadm.shtml .

2. Long-Term Supervised Housing

The availability of long-term supervised housing is a key element in all diversion programs. Three types of residences may house individuals with mental illnesses. These include mental health residential treatment facilities, assisted living facilities, and adult family-care homes. Also, these facilities may qualify as Medicaid assistive cares service providers if they house fewer than seventeen individuals. Statewide there are 116 mental health residential treatment facilities with a bed capacity of 1,925 and 747 assisted living facilities with a bed capacity of 13,962. A January 1, 2004 estimate of the number of severely and persistent mentally ill population in Florida is 320,007, with half of that population estimated to be eligible for publicly funded adult community mental health services. Obviously, there is a shortage of long-term supervised housing that would benefit this population.

D. Summary of Part VI

Jail diversion and aftercare programs in Florida are modeled on national standards. Pre-arrest Crisis Intervention Teams (CITs) are designed to divert the mentally ill to appropriate community mental health treatment upon contact with police in lieu of arrest. CITs are composed of volunteer police officers who have received at least 40 hours of specialized training. In Florida, standardized training modules are in development that include customized components such cultural diversity mental health issues. Reporting standards that include outcome information are also in development and will be shared with the state mental health program office. CITs currently exist in a five urban regions of the State of Florida.

Post-arrest mental health courts are designed to reduce jail time and obtain treatment for the mentally ill. Mental health courts for non-violent misdemeanor violators exist in six counties in the State of Florida. The mental health court was pioneered in Broward County. The Broward County mental health court continues as a national role model with the addition of a low level felony offender mental health court.

Post-incarceration jail linkage programs are designed to place a mentally ill inmate, upon release, in the care of the local community mental health system. Florida Assertive Community Treatment (FACT) teams are designed to provide 24 hours a day, 7 days a week, comprehensive mental health services delivered by a multidisciplinary treatment team that is responsible for identified individuals who have a serious mental illness. There are 30 FACT teams in 22 Florida counties treating over 2,000 individuals.

Long-term supervised housing is a key component in all mental health diversion programs in Florida. Mental health residential facilities, assisted living facilities and adult family-care homes provide such housing. However, the demand for such housing far exceeds their capacity in Florida.

PART VII

Perspectives from the Field: Survey Results from Sheriffs, Recent Studies of Orange and Sarasota Counties, and a Recent Miami-Dade County Grand Jury Report

In 1999, a survey of mental health services and procedures was conducted by the Louis de la Parte Mental Health Institute of the University of South Florida in each Florida jail with the assistance of DCF District Forensic Specialist. Initially, LCIR staff planned to perform a similar five-year follow-up survey for this review. However, four hurricanes then hit Florida in the summer of 2004 and these plans were curtailed because of county and DCF workload disruptions. Instead, a modified survey was sent to each Sheriff through the Florida Sheriffs Association. The original survey was sent out on September 30, 2004 and a follow-up request was sent on October 25, 2004. Twenty responses have been received to date from large, medium and small counties. Sometimes survey respondents did not answer all the questions or gave multiple responses to a question. Also, each Sheriff's Office that responded relied on several different individuals to complete the survey. The information provided through the LCIR survey of the Sheriff's office is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The survey was designed to examine the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. This survey does not include questions on pre-arrest (Crisis Intervention Teams) and post-arrest (Mental Health Courts) diversion programs that are known to exists in certain jurisdictions.

The questionnaire was organized in five sections (A- E). The sections include:

A. Baker Act Transportation Costs (Sheriff's Office and Jail)
B. Utilization of Florida Assertive Community Treatment (FACT) Programs
C. Challenges and Recommendations (opinions)
D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)
E. Additional Comments

A. Baker Act Transportation Costs

Respondents from 17 county Sheriffs' offices provided enough fiscal information on Baker Act transportation costs to calculate cost per trip to a Baker Act receiving facility such as a Crisis Stabilization Unit. A Crisis Stabilization Unit provides secure residential short-term acute care mental health services 24 hours a day seven days a week. The responses indicate that in the more rural counties without nearby receiving facilities, costs per trip were much higher than areas with nearby receiving facilities.

The respondent from Taylor County reported that Baker Act transportation costs per trip averaged $125 in fiscal years ending September 30, 2003 and 2004. At the other end of the cost spectrum was Palm Beach County, reporting $20 per trip in 2003 and $19 per trip in 2004. Ten Sheriffs' offices reported accounting for these costs in the Sheriff's general operating budget,

while jails paid for these costs in 4 counties. The lowest number of trips reported was 7 in 2003 in Nassau County. The most trips reported were 1,620 in 2004 in Polk County.

B. FACT Programs

The questionnaire asked about the utilization of the Florida Assertive Community Treatment (FACT) programs, if such programs exist in the community mental health system that serves inmates in the respondent's jail jurisdiction. In particular, the questionnaire asked about the effectiveness of the FACT program in lessening the impact of individuals with mental health problems on the Sheriff's deputies and the jail. Information on the FACT program was provided in 10 questionnaire responses as well as in two studies that examine mental health services in Orange and Sarasota Counties. Most of the comments were favorable, though some were qualified.

The Palm Beach County Sheriff's Office responded to the LCIR survey that there is the Psycho Therapeutic Services/ Palm Beach County FACT in its jurisdiction. The survey response states that the FACT helps by reducing recidivism.

> *If recidivism does occur the severity of mental illness is tempered by the FACT involvement in treatment. The frequency and intensity of behavioral problems are also reduced. The FACT team also maintains community support systems during a subject's incarceration, open communication with our mental health staff, advocacy services in the court system and routine on site supplementary visits.*

The Sheriff's Office in Polk County responded in a similar manner.

> *There are two mental health Programs in Polk County that provide community based FACT teams: Winter Haven Hospital and Peace River Center. They each have a FACT team. The case managers are required to monitor the individuals while they are incarcerated. They assist with getting the jail information helpful to the individual's treatment and also assist with aftercare plans upon the inmate's release.*

The Jacksonville Sheriff's Office stated that persons in its FACT program are arrested less often and released sooner. The Sheriff's Office in adjacent Nassau County reports that Baker Act individuals from their jail use the Mental Health Center of Jacksonville. However, admission to the Jacksonville FACT is infrequent, thus minimizing any benefit to the Nassau County jail.

The Alachua County Sheriff's Office response relative to the benefits of its FACT program was very positive. However, only two or three inmates receive FACT services at any given time due to funding limitations.

Santa Rosa County is served by the FACT program in adjacent Escambia County, which is contacted and initiates the person's release.

The St. Lucie Sheriff's Office reserved judgment on the effectiveness of the two FACT teams in their county in reducing arrest and jail admissions, saying they have not received, to date, any supporting data from the teams.

In contrast, the Mental Health Coordinator at the Leon County Jail expressed the following frustration with the local FACT Team.

> *Apalachee Center's FACT team does not provide any services to inmates in the Leon County Jail. Now and then a FACT client will be arrested and brought to the jail and FACT is aware the inmate is in jail. They fail to do anything to assist the inmate in getting released. There currently is a FACT inmate in the jail who is going through the competency evaluation procedure and most likely will be found incompetent to proceed.*

In summary, the survey results indicate FACT teams are well regarded. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

In addition to the survey, LCIR staff became aware of two relevant studies and a Grand Jury Report that provided some information relevant to the questions being asked in the survey. This information is presented, when appropriate, as no surveys were submitted by the Sheriff's Office of the three counties covered by these studies and the Grand Jury Report.

The Orange County study was conducted by the Center for Community Partnerships, College of Health and Public Affairs of the University of Central Florida and was funded by DCF and the Orange County Board of County Commissioners. The study focused the Orange County Central Receiving Center and reviewed best practices in community mental health and substance abuse services. The Orange County study concluded that its FACT program, operated by Lakeside Alternative, adheres to all the national standards that are associated with positive outcomes for its clients.

These FACT program national standards include a clinical staff/client ratio of 1:10, with specific specialist, including psychiatrists, a program assistant, a team leader, registered nurses, licensed mental health professionals, licensed or non-licensed masters level mental health/substance abuse specialist, mental health client peer specialist, mental health workers, and vocational educators. Other national standards that are empirically defined include staff roles, program size (100 maximum) and intensity, admission and discharge criteria, office space, hours of operation, team communication and planning, policy and procedure manual, and records and documentation. Although the study indicates that forensic mental health services are permissible if the eligibility criteria is met, no indication of actual involvement was mentioned. At the time this study was published in August of 2004, this FACT program served 100 people, with a waiting list of 28.

The Community Alliance of Sarasota County issued an Acute Care System Issue Analysis Report on January 27, 2003. According to this report, their FACT program, which serves

Sarasota and Desoto counties, was gearing up its capacity to the optimal maximum size of 100 clients, with 65 active clients at that time. No mention was made regarding the program's relationship with the judicial system.

C. Challenges and Recommendations

Knowledgeable personnel in each Sheriff's office were asked a series of questions in the LCIR survey related to the challenges and recommendations of delivering services to the mentally ill in their jails. Again, opinions were solicited on how the situation has changed in the last five years. The specific questions, listed as subheadings below, solicit responses about the biggest problems, challenges, effectiveness of services, barriers, and recommendations relating to the treatment and care of their jail's mentally ill inmates. The Orange County and Sarasota County reports as well as the Miami-Dade County Grand Jury Report are integrated into the responses when appropriate.

1. Relative to other problems your county's jails face, how big of a problem do inmates with mental illness pose compared to five years ago? [much less, less, about the same, more, much more]

Seventeen Sheriffs responded to this question. Eight of the respondents indicated that mentally ill inmates pose "much more" of a problem and six respondents said they pose "more" of a problem now than five years ago. Responses from Nassau and Okeechobee counties indicated "no change", while the Polk county response indicated having "less" of a problem now than five years ago. The Osceola and Hernando Counties Sheriffs' Offices indicated that the jails in their counties are separate from the Sheriff's Office.

The Alachua Sheriff's Office offered the following reasons why there is more of problem now posed by inmates with mental illness than five years ago:

1. *Longer waiting lists for state hospital beds*
2. *The judiciary in this community is beginning to use 'trans-institutionalization' as an option (i.e., using the county jail as a place to hold those inmates found incompetent to do incompetency training or further evaluation for determination of appropriate placement.)*

The long waiting list for state hospital beds was also mentioned in response to other questions in the Leon County and Santa Rosa County survey responses.

The Miami-Dade County Grand Jury Report provided a 20 year snapshot of change that illustrates the dramatic increase in inmates with psychiatric problems.

> *In fact, one of the clearest indicators of the crisis that exists in our community is the present situation at the Pre-trial Detention Center, commonly referred to as the Dade County Jail. The jail has nine (9) floors. In 1985, inmates with psychiatric problems occupied 2 out of 3 wings on <u>one</u> floor in the jail. Each inmate had his own bed and there were approximately eighty (80) such inmates.*

Today there are more than eight hundred to twelve hundred such inmates in the jail at any given time who are experiencing some form of mental illness. Some of their conditions are so severe, that they cannot be housed in the general population. Instead, these "chronic" cases now occupy 3 wings on three floors! Included in the group of inmates are defendants whose mental illness is so "acute" they are placed in safety cells and checked every fifteen minutes to prevent suicides or serious bodily injury.

2. What is the biggest challenge faced in managing inmates with a mental illness in your jails? Has this changed in the last five years?

Next, Sheriffs were asked to describe the biggest challenge faced in managing inmates with a mental illness in their jails. Seventeen responded, many citing multiple challenges. Only one respondent (Alachua) views its biggest challenge ("resources") as remaining the same over the last five years. All other respondents view their challenges as increasing in size.

The most frequently reported challenge was the housing of mentally ill inmates (7 mentions). The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice but to house the mentally ill with the general jail population, which creates problems. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent response (4 mentions each). Lack of training for jail staff in dealing with the mentally ill was mentioned three times.

The Levy County Sheriff's Office response illustrates several challenges in rural counties:

When they arrive, court proceedings seem to stop. For example, two inmates could have the same charges and arrive at the same time to the jail. If one of them has a mental illness, they could face up to three times the length of stay verses the one that presents without any mental illness. For the jail, it is hard to keep them separated from the other inmates due to the overcrowding. In addition, the cost of medication for these inmates once they are treated with medication averages between $580.00 to $800.00 (depending on the prescriptions). This has greatly increased in the past five years.

An interesting observation was made by the Medical Department Supervisor of the Nassau County Jail:

The biggest challenge faced by the jail in managing inmates with a mental illness has changed in the last five years. The tracking of medication and treatments administered through outside resources to inmates coming into or returning to jail with a mental illness has become more difficult.

A final illustration of challenges faced in managing inmates with a mental illness comes from the Okaloosa County Department of Corrections.

There are several challenges that include the following:

a. *Officers are not trained to deal with the mentally ill*
b. *Health services in jails are not staffed to deal with the mentally ill*
c. *A jail cannot force medication on a inmate that is non-compliant until they become dangerous*
d. *It is a revolving door as they get out and quit taking medications then return to jail*
e. *As they continue to come back the charges usually become more serious.*

3. How has the overall effectiveness of your jail's services for inmates with mental illness changed in the last five years?

Seventeen Sheriffs described changes in the overall effectiveness of their jails' services for inmates with mental illness. Five responses indicated a decline in effectiveness. Alachua County responded that the mentally ill population has gone up without an increase in staff, resulting in a decrease in effective services. Taylor County voiced a similar complaint. Nassau County cited increasing costs and decreasing availability of mental health professionals as problems. Palm Beach County mentioned that comprehensive mental health services have decreased. Levy County indicated that the local mental health service provider has cut down their service to 'emergency crisis screening' only and does not accept inmates needing hospitalization or counseling. The Levy county jail does not provide mental health services.

Two Sheriffs, in Bradford County and Santa Rosa County, indicated that the effectiveness of services for the mentally ill in their jails has changed little in the past five years. The Washington County response was that the jail staff was better prepared, but the lack of resources rendered them ineffective.

The responses of the Sheriffs' survey in seven counties were more positive. Duval County (Jacksonville) reported the effectiveness of their jails services for inmates with mental illness has improved in the last five years. Duval County further stated that this was

> *due to having a full time psychiatrist as part of our medical services contract, an increase in the number and availability of our mental health counselors, daily contact with the first appearance court judges by our court liaison and intensive training of our correction officers supervising the mentally ill. We divert more mentally ill inmates from the system sooner, and personnel trained in managing the mentally ill supervise those who remain incarcerated.*

The Leon County response illustrates a change toward privatization of mental health services in jail.

> *The Sheriff's Office now contracts with a private corporation, Prison Health Service (PHS) to provide all health care, including mental health. The decision to contract with a private corporation was largely due to the difficulty in hiring qualified personnel and the ever increasing costs associated with mental health care. On the average, the jail has a population of between 1,100 and 1,200*

inmates on any given day. There is one part-time psychiatrist and one full-time mental health coordinator responsible for delivering mental health services to the entire jail population.

The Okaloosa County response further amplifies potential benefits and challenges of privatizing mental health care.

> *The effectiveness has increased with the contracting of PHS as they screen all inmates entering the jail to determine if there is a history of mental illness as well as other medical problems. They also get medication verification quickly to provide a continuity of care in continuation of medication. The challenge has been that these inmates are causing an increase in Use of Force incidents of officers which leads to increase in costs and liability.*

The Okeechobee County Sheriff's Office responded that changes are made yearly to mental health services, depending on changing needs, and seems to work well. The Polk county response emphasized improved effectiveness through developing relationships with local mental health facilities and utilizing special needs units.

> *The mental health staff now can assist with placement of individuals who are to be released. Aftercare appointments are scheduled and contact with local mental health facilities have improved over the years. The special needs unit is a good idea in managing inmates while in jail.*

The Martin County Sheriff's Office responded in a similar manner to Okeechobee County and Polk County.

> *The service our facility provides has improved greatly. Our facility contracts its mental health services with New Horizons of the Treasury Coast and they provide all mental health services needed. We are continually reviewing our needs and institute changes when necessary. Statistics show the services provided have increased steadily over the past few years. This increase is partly from an increase in population, but can also be contributed to the increase of the services we provide, such as FACT team, drug treatment, etc.*

Finally, St. Lucie County identified the improvements to the provision of effective mental health service in their jail.

> *We have instituted processes that identify these patients immediately upon arrival at the facility and attempt to contact the attending medical provider to ascertain current medications, therapy, diet, etc. If the information can be obtained immediate action is taken to remain within established protocols of the community physician. Early identification, continuity of care during incarceration and upon release has increased the overall effectiveness in the St. Lucie County Sheriff's Office mental health program. Our community mental health provider*

(New Horizon) has a legislative budget request in for a Family Intervention Treatment Center to assist and enhance the current jail diversion program.

4. What is the biggest barrier to delivering more effective mental health services to inmates? Has this changed in the last five years, and if so how?

Sheriffs in 15 counties provided meaningful comments on barriers to delivering more effective mental health services to inmates. Costs or availability of medications was cited four times (Alachua, Duval, Leon, and Marion). The shortage or availability of community mental health resources was also mentioned four times (Duval, Leon, Levy, and Okaloosa). Funding issues were mentioned three times (Levy, Palm Beach, and Washington). A variety of other barriers were described in the responses, with several relating to communication.

Nassau County jail personnel describe a classic problem cited in research regarding communication.

> *Lack of communication between community mental health workers and the facility medical staff seems to be the biggest barrier in delivering more effective services to inmates. Without prior knowledge of former and current treatments an inmate has undergone the facility medical staff and mental health providers must evaluate the inmate and possibly administer treatments that have failed in the past. Therefore, prolonging a positive treatment outcome.*

This is a similar observation to that relayed by a Leon County respondent cited earlier in the survey results. The St. Lucie response lays some of the blame for difficulties in obtaining medical histories on the newer federal legislation that increases confidentiality of medical histories such as the Health Insurance Portability and Accountability Act of 1996.

There is another type of classic communication barrier that is described by the following response from Polk County jail staff.

> *The biggest barrier is communication between all the mental health parties involved with the inmate. Communication is poor between the public defender's office, the state attorney's office and even judges. It is difficult to schedule such things as aftercare appointments and placement when it is not known when an inmate is getting out of jail or what is happening with his case.*

Several other comments about barriers deserve mention. Palm Beach noted that the interaction of tight budgets, lack of physical facilities and an increasing mentally ill jail population has led to scaled back mental health services. The Taylor county jail administrator wants more receiving facilities, presumably closer by and made available to mentally ill inmates at his jail. Finally, personnel from the Sheriff's Office in Monroe County responded that they want a

> *Court Diversion Program for the mentally ill inmate, where they can be court ordered to a mental health institution.*

5. What would you recommend to alleviate the impact of the mentally ill on your county's jails?

The final policy-related question in the Challenges and Recommendations section asked for recommendations on how to alleviate the impact of the mentally ill on their county's jail. Seventeen survey responses were received on this question. Nine respondents advocated an increase in community mental health resources (Alachua, Bradford, Duval, Martin, Nassau, Okaloosa, Palm Beach, Polk, and St. Lucie Counties). Six respondents mentioned the need for additional secure community mental health facilities such as Crisis Stabilization Units or additional secure state mental health hospital beds (Marion, Okaloosa, Okeechobee, Santa Rosa, Taylor, and Washington Counties). Six respondents wanted to see the establishment of some form of diversion program such as a pre-arrest Crisis Intervention Team (Bradford, Duval, and St. Lucie Counties) or post-arrest Mental Health Court (Leon, Monroe, and Levy Counties). Four respondents mentioned the need for more affordable or assisted living or long-term care beds in their communities (Alachua, Marion, Polk, and St. Lucie Counties). Several responses are quoted below to illustrate these patterns.

Interestingly, the judicial circuit serving Alachua County has a respected mental health court as mentioned in the response from Taylor County. The Alachua Sheriff's recommendation for alleviating the impact of the mentally ill on the county jail follows.

1. *Community, judiciary and local government education in reference to the severity of this problem and address the need for funding further both for the jail and community programs to deal with mentally ill defenders. Locally, a Crisis Intervention Task Force has recently been formed and will assist with education and training.*
2. *Affordable community housing—housing in this community, as a result of being the home of a large University, is very expensive. The lack of affordable housing causes problems for people living on SSI as a result of mental illness. The lack of housing directly impacts the number of arrests for this population.*

Next, the Duval (Jacksonville) response addresses the dual need of pre-arrest diversion programs and maintaining sufficient community mental health resources. To lessen the impact of the mentally ill on the jail population:

> *Provide the appropriate amount of funding to maintain community based mental health services and ensure the community providers are considered a stakeholder in the criminal justice process for the mentally ill. Ensure the continuance of our mental health diversion program and our Crisis Intervention Team, a group of police, corrections and civilian personnel who receive advanced training in managing the mentally ill and are more familiarized with community resources.*

The Okaloosa County Department of Corrections response addresses the importance of community resource and nearby secure mental health receiving facilities.

The way to reduce the impact of the mentally ill in jails is to provide increased funding that would help provide services for them outside of the jails. There are not enough beds or agencies that provide emergency services nor is there enough funding to assist in follow-up care once they are released from custody. This county has two receiving facilities for Baker Act emergencies and both are located 40 to 50 minutes from the jail. Many law enforcement officers located in the vicinity of the jail will bring the mentally ill to jail as opposed to transporting them the extra hour to take them to a receiving facility.

The Miami-Dade County Grand Jury Report strongly recommended that every police department in Miami-Dade County create Crisis Intervention Teams with its uniformed officers. In addition, the report recommended that Miami-Dade county correctional officers in contact with mentally ill inmates receive CIT training.

D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB700)

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April, 2005.

Sixteen comments were received on how the implementation of SB700 will impact their Sheriff's Office and Jail. Results were mixed. Four responded that they did not know (Hernando, Marion, Nassau, and Palm Beach Counties). Three respondents stated there would be no change (Alachua, Okeechobee, and Taylor Counties). One respondent stated that there would be little change, unless funded (Leon County). Another respondent (Washington County) stated that their "facility is ill equipped and underfunded to deal with any mandated adjustments." Four respondents stated that their jails may receive a few more mentally ill inmates (Duval, Levy, Okaloosa, and Osceola Counties). In contrast, three respondents stated that implementation of involuntary outpatient commitments will have a positive impact on their Sheriff's Office and jail (Monroe, Polk, and St. Lucie Counties).

The Orange County Central Receiving Center study published in August of 2004 contains a section on involuntary outpatient placement. Major components include:

1. *ACT, Intensive Case Management, or other case management*
2. *Medication Evaluation and Management*
3. *Supportive Housing*
4. *Supportive Education/Supportive Employment*
5. *Psychotherapy (individual, family, group, rehabilitation, etc.)*
6. *Consumer Self-Help Initiatives.*

The report states that it is unknown what impact this change will have on Orange County's community mental health and substance abuse system and does not address any impacts on the jail system.

The Miami-Dade County Grand Jury Report noted that the Baker Act reform bill had no appropriation attached to it. The Report recommends that the Florida legislature:

> *provide funding to increase the number of community based mental health facilities and thereby increase the number and level of services available to the mentally ill in our state.*

E. Additional Comments

Respondents to the LCIR survey of the Sheriff's Office were invited to make any additional comments with regard to the mentally ill population and the county jail system. Fourteen responded. The thrust of the Alachua County Sheriff's Office's response was echoed by several other respondents as well as the Miami-Dade County Grand Jury Report. A portion of the Alachua County Sheriff's Office's response follows:

> *...unfortunately, the county jails have become de facto mental health institutions for counties. Detention Officers are not trained to handle these individuals versus mental health caseworkers, who would be; yet, they have charges placed against them and find themselves incarcerated. More dedicated community mental health dollars should be explored versus having these challenged individuals face arrest and/or conviction for crimes that could, perhaps, have been avoided with expanded community mental health treatment.*

The tenacity of community mental health workers is also seen as an important element in preventing the mentally ill from coming in contact with county jails. The Registered Nurse for the Levy County Jail, who also works as a part-time employee for Shands Hospital Vista, a mental health facility in Gainesville, Florida, offered the following comments.

> *I have seen many mental health clients get arrested when they have stopped taking their medications. This is very dangerous! If mental health clients were followed closer and not considered a 'closed case' when the client has missed appointments or landed themselves in jail, the end result might be beneficial for all.*

The Medical Contract Monitor for the Marion County Jail made the following comments.

> *In the past few years we have seen more severe and acute cases in our jails. These inmates get caught up in the Criminal Justice System and spend sometimes years going between jails and the State Hospital facilities. It appears that there are not enough beds in the State Mental Health System and inmates with Mental Illnesses get bottle necked in the County Jails.*

The Program Manager for the Okaloosa County Department of Corrections made the following comments on why the number of mentally ill is increasing in their jail population and suggests some changes.

It has been reviewed by many committees in an effort to learn why there is an increased level of mentally ill persons incarcerated. The problem seemed to increase with the closing of many residential treatment facilities. There have been fewer and fewer residential treatment facilities that offer housing and care to those who have criminal histories and there are no secure housing areas available other than the Florida State Hospital that assist in helping forensic clients become stable then return to the community. There are step programs available for those people with drug and alcohol problems that are secure then give them more freedom as they become able to accept it but with mental illness, the client is either in a secure setting such as jail or lockdown or in a non-secure setting where they can leave anytime they want. There is nothing that starts them in a secure setting, holds them until they are stable and gradually allows them passes into the community. This should be a process that evolves over three to six months of treatment then allows them to return to a non-secure setting. This state has reduced funding to programs across the state that offers any type of long term residential treatment to those with mental illness. This county has made progress, although slight, in attempting to increase the continuity of care once they are no longer incarcerated but since the court decisions are not known prior to court dates, many times the inmate is released without the case manager's knowledge so the inmate has very little medication and no follow-up doctor's appointment or even a place to live.

The Community Alliance of Sarasota County Acute Care Issue Analysis mentions that a lack of diversion programs for those persons with a mental illness who are arrested for misdemeanors and end up in jail is a major concern. Related concerns about community mental health services in general include a lack of publicly funded mental health and detoxification treatment beds; a lack of well-defined written protocols among mental health service providers, including law enforcement, out-of-county and transportation providers; and the lack of a well-defined leadership group that should be responsible for developing a community mental health system.

The Orange County study notes that the percentage of CIT trained law enforcement officers varies among law enforcement agencies within Orange County, generally falling below the nationally recommendations designed to achieve 24 hour full area coverage. Wide variation regarding communication between police dispatchers in the numerous police departments in Orange County and trained CIT personnel is cited as causing CIT officers not arriving on the scene in a timely manner.

F. Summary of Part VII

As a part of this review, each Sheriff's office was sent a survey by the LCIR in the fall of 2004. The survey was designed to elicit information from the experts in the Sheriff's office on the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system. Special emphasis was placed on how things have changed in the last five years. The survey questions were formulated to augment information collected at the state level on the impact of the mentally ill on county jails. Responses were received from twenty

Sheriff's offices from small, medium and large counties. The information provided through this survey is supplemented by recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

The Sheriff is responsible for providing Baker Act transportation. The reported costs per Baker Act trip was higher in the rural areas such as Taylor County ($125/ trip), served by remote Baker Act receiving facilities, than in more urban areas such as Palm Beach County ($20/trip) with nearby receiving facilities. The reported yearly number of Baker Act trips ranged from 7 in Nassau County to 1,620 in Polk County.

In general, FACT teams are well regarded as evidenced by the study and survey results reported in this section of the review. FACT teams would likely be welcome by jail personnel in counties that are currently not served by them. Additional FACT teams would probably be welcome in areas where they already exist, especially if they operate like those in Palm Beach, Polk, and Duval (Jacksonville) counties.

Most respondents indicated that mentally ill inmates pose a greater problem now than five years ago. The most frequently reported challenge faced in managing inmates with mental illness was this housing once in jail. The general feeling is that they require more intensive supervision and are associated with disciplinary problems when mixed with the general jail population. In small jails, respondents note that there is no choice, but to mix the mentally ill with the general population. Getting inmates to take prescribed medications and the rising costs of those medications was also a frequent problem cited along with the lack of training for jail staff in dealing with the mentally ill.

Most, but not all, respondents reported that the overall effectiveness of their jail's services for inmates with mental illness has declined in the last five years. Jurisdictions that reported improved services attributed the improvements to outsourcing of mental health services, increases in mental health staffing levels or improvements in communication with the local community mental health system.

The biggest barriers to delivering more effective mental health services were reported as being the costs or availability of medications, the shortage or availability of community mental health resources, funding, and communication. Conversely, respondents' recommendations to alleviate the impact of the mentally ill on their county jails included, in order of decreasing frequency: (1) increase community health resources, (2) add secure community mental health facilities or state mental health hospital beds, (3) establish some form of diversion program, and (4) add more affordable or assisted living or long-term care beds in their communities. Additional comments amplify these concerns and recommendations.

In 2004, the Baker Act was amended to allow for involuntary outpatient commitment to begin on January 1, 2005. DCF is amending Ch. 65E-5, F.A.C., to comply with this change, with an effective date expected in early April. Respondents' comments on the potential impact of these changes were mixed, ranging from no opinion, to no change, to a possible slight increase in mental health inmates. Several respondents viewed the changes favorably. State funding was

seen as a missing ingredient to potential benefits of the recent Baker Act changes by one respondent and echoed in the Miami-Dade County Grand Jury Report.

PART VIII

Significant Pending Issues at the Federal Level

Issues regarding the mentally ill and jail are not unique to Florida. In recognition of a nationwide mental health problem, President George W. Bush created the New Freedom Commission on Mental Health in 2002 to study national mental health issues, including those related to the criminal justice system, and make recommendations.[72] The Commission's Final Report was issued in July of 2003.[73] In addressing mental health problems in the criminal justice and juvenile justice systems, the Commission made the recommendation to widely adopt:

> *diversion and re-entry strategies to avoid the unnecessary criminalization and extended incarceration of non-violent adult and juvenile offenders with mental illnesses. HHS and the Department of Justice, in consultation with the Department of Education, should provide Federal leadership to help States and local communities develop, implement, and monitor a range of adult and youth diversion and re-entry strategies.*

The Mentally Ill Offender Treatment and Crime Reduction Act of 2004, S.1194, became Public Law No: 108-414 on October 30, 2004. This law directs that grants be used to create or expand mental health courts or other court-based programs, in-jail transitional services, specialized mental health training and services, and support intergovernmental cooperation between State and local governments with respect to the mentally ill offender. The law authorizes $50 million in FY 2005 and such sums as necessary for fiscal years 2006 through 2009.

The Miami-Dade County Grand Jury Report filed January 11, 2005 reported that the Miami Criminal Mental Health project was awarded a one million dollar grant from the federal Substance Abuse and Mental Health Administration to expand the existing pre and post jail diversion programs. The pre-arrest program follows the CIT model. The post-arrest program diverts eligible misdemeanor defendants to community mental treatment within 24 to 48 hours of arrest. This project includes a comprehensive case management program that addresses transition and housing issues as well as substance abuse.

The cost savings of a federally supplemented project such as the Miami Criminal Mental Health project pointed out in the Miami-Dade County Grand Jury Report are numerous:

1. The daily jail costs for housing which includes the feeding and treating the inmates in jail and the additional correctional officers who are needed to monitor the mentally ill jail population (for example, $125/day for mentally ill defendants versus $18/day for general population defendants in Miami-Dade County and $125/day for mentally ill defendants versus $78/day for general population defendants at the Broward County Jail).
2. The length of time mentally ill defendants stays in jail (up to eight times longer than the general population).

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[72] Executive Order 13263, President's New Freedom Commission on Mental Health.
[73] New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

3. Court Costs (may include at least one court-ordered and sometimes three psychiatric evaluations if requested by the public defender and state prosecutor for accused felons at the rate of $150/ evaluation in Miami-Dade County).
4. Expenses of the judge, court clerk, bailiff, prosecutor, defense attorney, court reporter, correctional officers and others who are present every time the case appears on a court calendar.
5. Costs of taking police officers off the street to appear for trials and hearings.

Federal funds dedicated to adult mental health and especially the mental health of those incarcerated are scarce but do exist.

PART IX

Major Findings

This part describes major findings, drawn from previous studies, the LCIR survey of Sheriffs' offices in Florida, and recent studies related to the community mental health systems in Orange and Sarasota counties and a recent Miami-Dade County Grand Jury Report.

- Community mental health services in Florida are funded by federal, state, and local-matching funds. Local-matching funds are generally required by statute to draw down federal grants. Medicaid does not have a local-matching requirement and is now the major funding source in the federal-state-local mix.
- The courts have interpreted the 8th Amendment to the U.S. Constitution, prohibiting cruel and unusual punishment, to require the provision of basic mental health care in prisons and jails such as systematic screening and evaluation, treatment including making medications available, and suicide prevention.
- Medications and services provided to the mentally ill in jail are funded by the county. Increases in the costs of anti- psychotic medication are a frequently cited problem by Florida jail personnel.
- Although jails in Florida screen for mental illness and have suicide prevention programs, with larger jails providing more elaborate treatment and in-jail housing options, resources within the criminal justice system necessary to cope with the mentally ill are inadequate.
- Inadequate public funding for community mental health services is widely viewed as negatively impacting the treatment of the mentally ill in Florida, limiting the ability of the criminal justice system to divert the mentally ill from jail to more appropriate community mental health settings, and limits aftercare of the mentally ill upon release from jail. Funding of recent changes to the Baker Act allowing involuntary outpatient placement is seen as important, if not essential, to its implementation.
- The most prevalent pre-booking diversion program recognized as a best practice and present in Florida is the police-based Crisis Intervention Team (CIT). CITs exist in various police departments in large urban counties. Recent studies report that not all elements of a model CIT in at least some CITs. Florida state mental health program staff indicates that training modules and reporting practices are still under development.
- Post-booking diversion programs must include a negotiation that reduces penalties or waives penalties pending successful completion. Studies indicate that a significant number of jails that claim to have a jail diversion programs fail in this criterion. Mental health courts for individuals with mental illness who have been charged with a non-violent misdemeanor offense are another type of post-arrest diversion program, existing in five Florida counties. Broward County has the longest standing mental health court and now includes individuals charged with low-level felonies.
- Post-incarceration programs rely on linkages to effective community treatment programs. The program of choice at this time is the Florida Assertive Community Treatment (FACT) team. Currently, there are 30 operational FACT teams in Florida, with others in the process of being activated. Essentially, FACT teams treat the most severely mentally ill individuals around the clock with diverse and specialized mental health and vocational services, assisted living and intensive team case management.

PART X
Recommendations

The LCIR approved the following recommendations:

- Monitor Florida's utilization of federal grant monies made available by P.L 108-414 and other federal sources and support future funding.
- Encourage and support the Department of Children and Families in developing the training and reporting components of the police-based Crisis Intervention Team programs and other pre-arrest diversion programs as deemed appropriate by local community mental health systems. In the past, costs have been shared among the program developers and program beneficiaries.
- Continue to fund and expand the Florida Assertive Community Treatment teams and encourage routine communication with the judicial system, especially appropriate jail personnel.
- Continue to utilize federal matching dollars to the extent possible for the delivery of community mental health case management and services.
- Encourage the Department of Children and Families to work with the federal government to promote that more flexible spending requirements be attached to federal funding sources, coupled with outcome reporting requirements.

Attachment 1

Standards for Assisted Treatment: State by State Summary

Standards for Assisted Treatment: State by State Summary

Last updated July 12, 2004
print the PDF version of this file

ADDITIONAL INFORMATION
text summary by state | database of preventable tragedies | consequences of nontreatment | myths about assisted treatment | press room

This chart captures the most essential information about the laws for assisted treatment in each state, including the following information.

Need For Treatment
States with this column marked have a standard for assisted treatment that includes eligibility criteria permitting the placement in treatment of those overcome by mental illness based on the need for treatment. The standard in such a state normally includes other requirements, such as the inability to make an informed medical decision. Some standards that are arguably need for treatment based standards have not been classified as such because of their limited scope. For instance, the first generation "gravely disabled" standard found in many states requires that a person be unable to access food, shelter, etc., to a degree that causes a substantial physical danger has not been classified as a need for treatment standard. Whereas, those gravely disabled standards that allow for treatment based on a person's inability to provide for needed psychiatric care have been designated as need for treatment based criteria. The standards of exactly half of the states and the District of Columbia met or exceeded this limited need for treatment threshold.

Assisted Outpatient Treatment (AOT)
States with this column marked allow for assisted outpatient treatment, which is a form of court-ordered treatment on an outpatient basis. Classified as states that do not have AOT are those that allow for the conditional release of patients already under inpatient treatment orders but not direct placement in court-ordered outpatient treatment of those who are not. Forty-two states have laws for assisted outpatient treatment (although far fewer make effective use of those laws).

Relevant Code Sections
The sections of the state's code containing the standard for treatment placement. Language is available at www.psychlaws.org.

Standard
This is a summary of the state's standard for treatment placement. These are the key elements of the state's requirements for the placement in treatment of a person who refuses treatment because of the symptoms of mental illness. Please take note that while these descriptions do contain much of each standard's actual language, they are summaries of only the most crucial provisions of the pertinent statutes for each state.

State	Need For Treatment	AOT	Relevant Code Section	Standard
Alabama	x	x	Ala. Code § 22-52-10.4 § 22-52-10.2	**Inpatient:** A real and present danger to self/others, without treatment will continue to suffer mental distress and deterioration of ability to function independently, and unable to make a rational and informed decision concerning treatment. **Outpatient:** Without treatment will continue to suffer mental distress and deterioration of the ability to function independently and the respondent is unable to make a rational and informed decision concerning treatment.
Alaska	x	x	Alaska Stat. § 47.30.755(a) § 47.30.915(2) § 47.30.915(10)	**Inpatient and Outpatient:** (1) Danger to self/others; (2) in danger from inability to provide basic needs for food, clothing, shelter, or personal safety; or (3) without treatment will suffer severe and abnormal mental, emotional, or physical distress causing deterioration of ability to function independently.
Arizona	x	x	Ariz. Rev. Stat. § 36-540(A) § 36-501(5), (6), (16), (33)	**Inpatient and Outpatient:** (1) Danger to self/others; (2) in danger from inability to provide basic physical needs; or (3) likely to suffer severe and abnormal mental emotional or physical harm without treatment, likely to benefit from treatment, and substantially impaired capacity to make informed decisions regarding treatment.
Arkansas		x	Ark. Code Ann. § 20-47-207(a)	**Inpatient and Outpatient:** (1) Clear and present danger to self/others or (2) needs hospitalization, behavior history demonstrates that he/she lacks the capacity to care for own welfare that there is a reasonable probability of death, serious bodily injury, or serious physical or mental debilitation.
California		‡	Calif. Welf. & Inst. Code § 5250; § 5008(h)(1); § 5346(a)	**Inpatient:** (1) Danger to self/others or (2) unable to provide for basic personal needs for food, clothing, or shelter. **Outpatient:** Condition likely to substantially deteriorate, unlikely to survive safely in community without supervision, history of noncompliance which includes two hospitalizations in past 36 months or act/threat/attempt of violence to self/others in 48 months immediately preceding petition filing, likely needs to prevent meeting inpatient standard, and likely to benefit from assisted treatment. **‡Note:** Separate outpatient standard only available in counties that have adopted provisions established by Assembly Bill 1421 (2002) (a.k.a. Laura's Law); otherwise mandated outpatient treatment only permitted via conservatorship process.

Colorado	x	x	Colo. Rev. Stat. § 27-10-111(1)(c), § 27-10-102(5)	**Inpatient and Outpatient:** (1) Danger to self/others; (2) in danger of serious physical harm due to inability to provide essential human needs of food, clothing, shelter, and medical care; cannot manage resources or conduct social relations so that health or safety significantly endangered and lacks capacity to understand need; or (4) criteria allowing for those in need of care of because of pending loss of support of relative who is a caregiver.
Connecticut			Conn. Gen. Stat. Ann. § 17a-498(c) § 17a-495(a)	**Inpatient:** (1) Danger to self/others or (2) in danger of serious harm from inability to provide for basic needs such as essential food, clothing, shelter or safety and unable to make a rational and informed decision concerning treatment.
Delaware	x	x	Del. Code Ann. tit. 16, § 5001(6) tit. 16, § 5010	**Inpatient and Outpatient:** Real and present danger to self/others/property, in need of treatment, and unable to make responsible decisions with respect to hospitalization.
District of Columbia		x	D.C. Code Ann. § 21-545(b)	**Inpatient and Outpatient:** Danger to self/others.
Florida	x	x	Fla. Stat. Ann. § 394.467(1) § 394.4655(1)	**Inpatient:** Unable or refuses to make responsible decisions with respect to voluntary placement for treatment AND either (1) without treatment incapable of surviving alone or with the help of willing family or friends, and likely to suffer from neglect or refuse to care for himself/herself that will pose a real and present threat of substantial harm to well-being OR (2) danger to self/others as evidenced by recent behavior. **Outpatient:** Unlikely to survive safely in the community without supervision, history of noncompliance which includes two hospitalizations in past 36 months or acts/threats/attempt of violence to self/others in 36 months immediately preceding petition filing, unlikely to voluntarily participate, needs in order to prevent relapse or deterioration likely to result in serious harm to self/others, and likely to benefit from assisted treatment.
Georgia	x	x	Ga. Code Ann. § 37-3-1(9.1) § 37-3-1(12.1)	**Inpatient:** In need of involuntary treatment AND (1) imminent danger to self/others, evidenced by recent overt acts or expressed threats of violence OR (2) unable to care for physical health and safety so as to create an imminently life-endangering crisis and in need of involuntary treatment. **Outpatient:** Based on treatment history or current mental status, requires outpatient treatment in order to avoid predictably and imminently becoming an inpatient and unable to voluntarily seek or comply with outpatient treatment.

Hawaii	x	x	Haw. Rev. Stats. § 334-60.2 § 334-121 § 334-1	**Inpatient:** In need of treatment AND either (1) imminent danger to self/others, including that of substantial emotional injuries to others, OR (2) unable to provide for basic personal needs for food, clothing, or shelter, unable to make or communicate rational decisions concerning personal welfare, and lacking the capacity to understand that this is so, OR (3) behavior and previous history indicate a disabling mental illness and unable to make rational decisions concerning treatment. **Outpatient:** Either previous inpatient hospital treatment for a severe mental disorder or chronic substance abuse OR previously been imminently dangerous to self/others OR meets no.2, above AND capable of surviving safely in the community with available supervision; based on the treatment history and current behavior, treatment is needed to prevent deterioration predictably resulting in imminent danger to self/others, unable to make rational decisions concerning treatment, and the outpatient treatment ordered is likely to be beneficial.
Idaho	x	x	Idaho Code § 66-329(k) § 66-317(k), (m) § 66-339A	**Inpatient:** (1) Danger to self/others or (2) in danger of serious physical harm due to inability to provide for essential needs. **Outpatient:** Without treatment likely to become danger to self /others, lacks capacity to make informed treatment decisions, previous psychiatric hospitalization, previously failed to substantially comply with the prescribed course of outpatient treatment, and patient's disorder likely to respond to the treatment.
Illinois		x	405 Ill. Comp. Stat. 5/1-119	**Inpatient and Outpatient:** (1) Danger to self/others, explicitly including threatening behavior or conduct that places another individual in reasonable expectation of being harmed, or (2) unable to provide for basic physical needs so as to guard against serious harm without the assistance of others.
Indiana	x	x	Ind. Code Ann. § 12-7-2-53 § 12-7-2-96 § 12-26-7-5(a) § 12-26-14-1 § 12-26-6-8-(a)	**Inpatient:** (1) danger to self/others; or in danger of coming to harm because either (2) unable to provide for food, clothing, shelter, or other essential human needs OR (3) substantial impairment or obvious deterioration that results in inability to function independently. **Outpatient:** Same as for inpatient except must also be likely to benefit from the recommended outpetient treatment program and not be likely to meet inpatient standard if compliant with the recommended program.
Iowa		x	Iowa Code § 229.14 § 229.1(19)	**Inpatient and Outpatient:** Lacks sufficient judgment to make responsible decisions concerning treatment AND is either (1) a danger to self/others, including that of serious emotional injuries to family members and others OR (2) unable to satisfy need for nourishment, clothing, essential medical care, or shelter so that it is likely that the person will suffer physical injury, physical debilitation, or death.

Kansas		x	Kan. Stat. Ann. § 59-2946a(f)(1) § 59-2967(a)	**Inpatient:** Lacks capacity to make informed decision concerning treatment AND either (1) danger to self/others/property OR (2) substantially unable to provide for basic needs, such as food, clothing, shelter, health or safety. **Outpatient:** Same as for inpatient except must *also be likely to comply* with outpatient treatment order and not likely be danger to self/others/community while subject to outpatient treatment order.
Kentucky			Ky. Rev. Stat. Ann. § 202A.026 § 202A.011(2)	**Inpatient and Outpatient:** Danger to self/others/family, including actions which deprive self/others/family of basic means of survival such as provision for reasonable shelter, food or clothing; can reasonably benefit from treatment and hospitalization is the least restrictive form of treatment available. † Note: Kentucky allows for only a 60 day period on AOT and a possible single 60 day renewal period that must be agreed to by all parties.
Louisiana		x	La. Rev. Stat. Ann. § 28:55(E)(1) § 28:2(3), (4), (10)	**Inpatient and Outpatient:** (1) Danger to self/others or (2) unable to provide for basic physical needs, such as essential food, clothing, medical care, and shelter, and unable to survive safely in freedom or guard against serious harm.
Maine			Me. Rev. Stat. Ann. tit. 34-B, § 3864(6)(A) tit. 34B, § 3801(4)	**Inpatient:** Inpatient hospitalization is the least available means for treatment of the patient, the Court is satisfied with the submitted treatment plan AND, based on recent actions or behavior, either (1) danger to self/others OR (2) severe *mental impairment* or injury likely to result unless treatment plus a determination that outpatient community resources or home care and treatment are unavailable.
Maryland			Md. Code Ann., Health-Gen. § 10-632(e)(2)	**Inpatient:** Danger to self/others, in need of treatment, and unable or unwilling to be voluntarily admitted.
Massachusetts			Mass. Gen. Laws Ann. ch. 123, § 8(a) ch. 123, § 1	**Inpatient:** (1) Danger to self/others or (2) very substantial risk of physical impairment or injury because unable to protect himself/herself in the community.
Michigan	x	x	Mich. Comp. Laws Ann. § 330.1401	**Inpatient and Outpatient:** (1) Danger to self others; (2) unable to attend to basic physical needs such as food, clothing, or shelter necessary to avoid serious harm in the near future; or (3) unable to understand need for treatment and continued behavior reasonably expected to result in significant physical harm to self/others.

Minnesota		x	Minn. Stat. Ann. § 253B.09(1) § 253B.02(13)(a)(17) § 253B.065(5)(b)	**Inpatient**: (1) A clear danger to either OR (2) likelihood of physical harm to self/others demonstrated by either (2) failure to obtain necessary food, clothing, shelter, or medical care as a result of impairment OR (3) inability to obtain necessary food, clothing, shelter or medical care and is more probable than not will suffer substantial harm, significant psychiatric deterioration or debilitation or serious illness OR (4) a recent attempt or threat to harm self/others OR (5) recent, volitional conduct involving significant damage to property. Outpatient: Meet one of the criteria from the inpatient standard AND either (1) manifestations interfere with ability to care for self and, when competent, would choose substantially similar treatment OR (2) has had at least two court-ordered hospitalizations in past three years, exhibits symptoms/behaviors substantially similar to those preceding one or more of those hospitalizations, and is likely or expected to deteriorate to inpatient criteria unless treated.
Mississippi	x	x	Miss. Code Ann. § 41-21-73(4) § 41-21-61(e)	**Inpatient and Outpatient**: A substantial likelihood of physical harm to self/others as demonstrated by (1) a recent attempt or threat to harm self/others or (2) failure to provide necessary food, clothing, shelter or medical care. Explicitly includes person who, based on treatment history, is in need of treatment to prevent further disability or deterioration predictably resulting in danger to self/others if unable to make informed decisions concerning treatment.
Missouri		x	Mo. Ann. Stat. § 632.335(4) § 632.005(9) § 632.350(5)	**Inpatient and Outpatient**: (1) Likelihood of serious harm to self/others; (2) Likelihood that serious physical harm will result due to impairment in capacity to make treatment decisions, evidenced by inability to provide for basic necessities of food, clothing, shelter, safety, medical care, or necessary mental health care. Evidence may also include past patterns of behavior.
Montana	x	x	Mont. Code Ann. § 53-21-126(1) § 53-21-127(7)	**Inpatient and Outpatient**: In determining whether the respondent requires commitment, the court shall consider the following (1) whether substantially unable to provide for basic needs of food, clothing, shelter, health, or safety; (2) whether recently caused self-injury or injury to others; (3) whether imminent danger to self/others; and (4) whether the respondent's mental disorder, demonstrated by the respondent's recent acts or omissions, will, if untreated, predictably result in deterioration to meet considerations nos. 1, 2 or 3. Predictability may be established by the respondent's relevant medical history. Commitments based solely on consideration no. 4 must be on an outpatient basis.

Nebraska		x	Neb. Rev. Stat. § 83-1037 § 83-1009	**Inpatient and Outpatient:** (1) Danger [illegible] self/others, as manifested by recent threats/acts of violence or (2) substantial risk of serious harm evidenced by inability to provide for basic human needs, including food, clothing, shelter, essential medical care, or personal safety.
Nevada			Nev. Rev. Stat. § 433A.310(1) § 433A.115	**Inpatient:** Clear and present danger of harm to self/others and diminished capacity to conduct affairs, social relations, or care for personal needs. *Explicitly includes the inability, without assistance,* to satisfy need for nourishment, personal/medical care, shelter, self-protection or safety which will result in a reasonable probability that death, serious bodily injury or physical debilitation will occur within the next following 30 days.
New Hampshire	x	x	N.H. Rev. Stat. Ann. § 135-C:34 § 135-C:27	**Inpatient and Outpatient:** A potentially serious likelihood of danger to self/others as evidenced by either (1) recent infliction of serious bodily injury, attempted suicide, or serious self injury in last 40 days which is likely to reoccur without treatment, (2) threatened *infliction* serious bodily injury by self in last 40 days, and that without treatment an act or attempt of serious self-injury will likely occur, (3) lacks capacity to care for own welfare and is in likelihood of death, serious bodily injury, or serious debilitation, (4) severely mentally disabled for at least one year, involuntary admission within last 2 years, refusal of necessary treatment and [illegible] substantial probability that refusal will [illegible] death, serious bodily injury or serious deterioration, OR (5) threatened, attempted or actual [illegible] violence in last 40 days.
New Jersey			N.J. Stat. Ann. § 30:4-27.2(m), (r), (h), (i)	**Inpatient:** Danger to self/others/property, unwilling to be admitted voluntarily, and in need of treatment. Danger to self explicitly includes the inability, without assistance, to satisfy need for nourishment, essential medical care or shelter.
New Mexico			N.M. Stat. Ann. § 43-1-11(C) § 43-1-3(M), (N)	**Inpatient:** Danger to self /others, likely to benefit from treatment, and proposed commitment is consistent with treatment needs and least drastic means. Harm to self includes grave passive neglect.
New York	x	x	N.Y. Mental Hyg. Law § 9.31(c) § 9.01 § 9.60(C)	**Inpatient:** Danger to self/others, treatment in hospital is essential to welfare, and is unable to understand need for care and treatment. **Outpatient:** Unlikely to survive safely in community *without supervision*, history of noncompliance which includes two hospitalizations in past 36 months or acts/threat/attempt of violence to self/others in 48 months immediately preceding petition filing, unlikely to voluntarily participate, needs in order to prevent relapse or deterioration likely to result in serious harm to self/others, and likely to benefit from assisted treatment.

North Carolina	x	x	N.C. Gen. Stat. § 122C-268(j); § 122C-3(11); § 122C-267(h); § 122C-263(d)(1); § 122C-271(a)	**Inpatient**: Danger to self/others/property. Explicit includes reasonable probability of suffering serious physical debilitation from the inability to withou assistance; either exercise self-control, judgment and discretion in conduct and social relations; or satisfy need for nourishment, personal or medica care, shelter, or self-protection and safety. **Outpatient**: Capable of surviving safely community with available supervision, in need treatment to prevent further deterioration predictably resulting in dangerousness, or inability to make informed decisions to seek or with voluntary treatment.
North Dakota	x	x	N.D. Cent. Code § 25-03.1-07 § 25-03.1-02(12)	**Inpatient and Outpatient**: Danger to self/others/property if not treated. Harm to self includes substantial likelihood of deterioration in physical health/substantial injury/disease/death, based upon recent poor self-control or judgment in providing shelter/nutrition/personal care; or substantial deterioration in mental health predictably resulting in danger to self/others/property based upon objective facts of loss of cognitive or volitional control over thoughts or actions or based upon history, current condition, effect of mental condition on ability to consent.
Ohio		x	Ohio Rev. Code Ann. § 5122.15(C) § 5122.01(B)	**Inpatient and Outpatient**: (1) Danger to self/others; (2) substantial and immediate risk of serious physical impairment or injury to self as manifested inability to provide for basic physical needs and provision for needs is unavailable in community; or (3) needs and would benefit from treatment as evidenced by behavior creating grave and imminent risk to substantial rights of others/self.
Oklahoma	x	x	Okla. Stat. Ann. tit. 43A, § 1-103(13)a. tit. 43A, § 1-103(18)	**Inpatient and outpatient**: (1) Danger to self/others evidenced by recent acts/threats; (2) severe impairment/injury will result from inability to avoid/protect self from impairment/injury; (3) serious harm in near future from inability to provide basic needs and needs not immediately available in community; or (4) person appears to require inpatient treatment and treatment is reasonably believed to prevent progressively more debilitating mental impairment.
Oregon	x	x	Or. Rev. Stat. § 426.005(1)(d)	**Inpatient and Outpatient**: (1) Danger to self/others; (2) unable to provide for basic personal needs and is not receiving care necessary for health/safety; or (3) chronic mental illness, two hospitalizations in previous three years, symptoms/behavior substantially similar to those that led to the previous hospitalizations, and will continue to physically or mentally deteriorate to either standard (1) or (2) if untreated.

Pennsylvania		x	50 Pa. Cons. Stat. Ann. § 7301(A). § 7304(f)	**Inpatient and Outpatient**: Clear and present danger to self/others; includes inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety, and reasonable probability that death, serious bodily injury or serious physical debilitation would ensue within 30 days.
Rhode Island		x	R.I. Gen. Laws § 40.1-5-8(i) § 40.1-5-2 (7)(i) § 40.1-5-2 (8)	**Inpatient and Outpatient**: In need of care/treatment in a facility and, if unsupervised in the community, would be a danger to self/others. Explicitly includes substantial risk of harm manifested by grave, clear and present risk to physical health and safety.
South Carolina	x	x	S.C. Code Ann. § 44-17-580 § 44-23-10(1),(2)	**Inpatient and Outpatient**: Needs treatment and either (1) unable to make responsible decisions with respect to treatment; OR (2) likelihood of serious harm to self/others, including the substantial risk of physical impairment from inability to protect oneself in community and provisions for protection are unavailable.
South Dakota	x	x	S.D. Codified Laws § 27A-1-2 § 27A-1-1 (4), (5)	**Inpatient and Outpatient**: Danger to self /others, as evidenced by treatment history and recent acts, and needs and is likely to benefit from treatment. Danger to self includes danger of serious personal harm in the very near future evidenced by inability to provide for basic human needs such as food, clothing, shelter, physical health, or personal safety, or arrests or criminal behavior due to mental illness.
Tennessee			Tenn. Code Ann. § 33-6-501	**Inpatient**: Substantial likelihood of serious harm, which includes the inability to avoid severe impairment or injury from specific risks.
Texas	x	x	Tex. Health & Safety Code Ann. § 574.034 § 574.034 § 574.034 § 574.035	**Inpatient**: (1) Danger to self/others; or (2) severe and abnormal mental, emotional or physical distress; substantial mental or physical deterioration of ability to function independently, exhibited by the inability to provide for basic needs, including food, clothing, health, or safety; and inability to make rational and informed treatment decisions. **Outpatient**: (1) Danger to self/others or (2) severe and persistent mental illness. If untreated will cause severe and abnormal mental, emotional, or physical distress; and deterioration of the ability to function independently and inability to live safely in community; and inability to voluntarily and effectively participate in outpatient treatment as demonstrated by actions of past two years or the inability to make an informed treatment decision.
Utah		x	Utah Code Ann. § 62A-15-631 (10)62A-15-	**Inpatient and Outpatient**: Inability to make rational treatment decision and immediate danger to self/others, explicitly including both inability to provide basic necessities such as food, clothing, and shelter and substantial risk of extreme physical

			602 (12) 62A-15-602 (13)	pain, protracted and obvious disfigurement, or protracted loss or impairment of mental faculty.
Vermont	x	x	Vt. Stat. Ann. tit. 18, § 7611 tit. 18, § 7101(16) tit. 18, § 7101(17)	**Inpatient and Outpatient:** (1) Danger to self/others and (2) a patient who is receiving adequate treatment, and who, if such treatment is discontinued, is likely to deteriorate to the point in (1). Danger to others includes presenting a danger to persons in his/her care. Danger to self can be the inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety, so that probable death, substantial physical bodily injury, serious mental deterioration or physical debilitation or disease will ensue.
Virginia	h	x	Va. Code Ann. § 37.1-67.3 § 37.1-67.3	**Inpatient:** (1) Imminent danger to self/others; or (2) so seriously mentally ill as to be substantially unable to care for self. **Outpatient:** Same as for inpatient plus is competent to understand the stipulations of treatment, wants to live in community and agrees to abide by treatment plan, has capacity to comply with treatment plan, ordered treatment can be delivered on outpatient basis, and can be monitored by community services board or designated providers.
Washington	x	x	Wash. Rev. Code Ann. § 71.05.240 § 71.05.020(1) § 71.05.020(1) § 71.05.020(19) § 71.05.020(21)	**Inpatient:** (1) Danger to self/others, proof of; in danger of serious physical harm from failure to provide for essential human needs of health or safety; or (3) severe deterioration in routine functioning evidenced by loss of cognitive or volitional control and not receiving [illegible] **Outpatient:** Same as inpatient, if proof of treatment is in best interest of patient
West Virginia		x	W. Va. Code § 27-5-4(j) §27-1-12	**Inpatient and Outpatient:** Danger to self/others. Danger to others includes presenting a danger to persons in his/her care. Danger to self can be the inability, without assistance, to satisfy need for nourishment, personal or medical care, shelter, or self-protection and safety, so that probable death, substantial physical bodily injury, serious mental deterioration or physical debilitation or disease will ensue.

Wisconsin	x	x	Wis. Stat. Ann. § 51.20(1)(a)1 § 51.20(1)(a)2	**Inpatient and Outpatient:** (1) Danger to self/others as evidenced by recent acts/threats; (2) substantial probability of physical impairment/injury to self as evidenced by recent acts/omissions; (3) inability to satisfy basic needs for nourishment, medical care, shelter or safety so that substantial probability of imminent death, serious physical injury, serious physical debilitation or serious physical disease; or (4) substantial inability to make informed treatment choice, needs care or treatment to prevent deterioration, and substantial probability that untreated will lead to serious harm to health or safety and suffer severe mental, emotional or physical harm that will result in the loss of ability to function in community or loss of cognitive or volitional control over thoughts or actions.
Wyoming	x	x	Wyo. Stat. Ann. § 25-10-110(i) § 25-10-101(a)(ix) § 25-10-101(a)(ii) § 25-10-110(i)(ii)	**Inpatient and Outpatient:** (1) Danger to self/others; (2) unable, without available assistance, to satisfy basic needs for nourishment, essential medical care, shelter or safety so it is likely that death, serious physical injury, serious physical debilitation, serious mental debilitation, destabilization from lack of or refusal to take prescribed psychotropic medications for a diagnosed condition or serious physical disease will imminently ensue.

Attachment 2

LCIR Survey Respondents and Other Sources of Information by County

Sheriff's Response	Response
ALACHUA	Yes
BRADFORD	Yes
DUVAL	Yes
HERNANDO	Yes
LEON	Yes
LEVY	Yes
MARION	Yes
MARTIN	Yes
MIAMI-DADE	Grand Jury Report
MONROE	Yes
NASSAU	Yes
OKALOOSA	Yes
OKEECHOBEE	Yes
ORANGE	Study
OSCEOLA	Yes
PALM BEACH	Yes
POLK	Yes
SAINT LUCIE	Yes
SANTA ROSA	Yes
SARASOTA	Study
TAYLOR	Yes
VOLUSIA	Yes
WASHINGTON	Yes
TOTAL	20 Survey responses

Attachment 3

LCIR Survey

Mental Health Issues and County Jails

The Florida Legislative Committee on Intergovernmental Relations (LCIR) is conducting an interim research project examining the processes, costs, and challenges relating to individuals with mental health problems that come in contact with the county jail system.

This questionnaire is designed to be answered by each Sheriff. These questions are designed to augment information collected at the state level on the impact of the mentally ill on county jails. This survey does not include questions on pre-arrest (Crisis Intervention Teams) and post-arrest (Mental Health Courts) diversion programs that are known to exists in certain jurisdictions.

The questionnaire is organized in five sections (A.- E.), preceded by some basic contact questions. The sections include:

F. Baker Act Transportation Cost (Sheriff's Office and Jail)
G. Utilization of Florida Assertive Community Treatment (FACT) Programs
H. Challenges and Recommendations (opinions)
I. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)
J. Additional Comments are Solicited

We would like to thank you in advance for your cooperation. Please return the completed survey by **Friday, October 16th by e-mail** to Dick Drennon, Senior Legislative Analyst with the LCIR at drennon.dick@leg.state.fl.us or by facsimile transmission at 850-4876587. Please contact Dick Drennon at 850-410-1478 if you have any questions regarding this study.

Basic Contact Information

1. Sheriff
County:
Sheriff's Name:
Person/Title for Follow-up Contact:
Contact's Phone:
Contact's E-mail:

A. Baker Act Transportation Cost (Countywide Sheriff's Office and Jails)

1. How much did transportation of persons under the Baker Act cost the Sheriff's Office in county fiscal year ending September 30, 2003? How many trips does that represent? How much time does that represent in terms of full-time employees? [For example, 1.25 full time deputies].
2. How much do you estimate that the transportation of persons under the Baker Act will cost the Sheriff's Office in county fiscal year ending September 30, 2004? How many trips does that represent? How much time does that represent in terms of full-time employees?
3. Are these costs accounted for in the county jail budget or the Sheriff's general operating budget?
4. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

B. Utilization of Florida Assertive Community Treatment (FACT) Program

1. Does the community mental health system that serves inmates of this jail have a FACT Program? If so, please describe its effectiveness in lessening the impact of individuals with mental health problems on your deputies and the jail.
5. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

C. Challenges and Recommendations

1. Relative to other problems your county's jails face, how big of a problem do inmates with mental illness pose compared to five years ago? [much less, less, about the same, more, much more]
2. What is the biggest challenge faced in managing inmates with a mental illness in your jails? Has this changed in the last five years?
3. How has the overall effectiveness of your jails' services for inmates with mental illness changed in the last five years?
4. What is the biggest barrier to delivering more effective mental health services to inmates? Has this changed in the last five years, and if so how?
5. What would you recommend to alleviate the impact of the mentally ill on your county's jails?
6. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

D. Potential Impact of Recent Baker Act Legislation (Ch. 2004-385, L.O.F. also known as SB 700)

1. Please comment on how the implementation of SB700 will impact your Sheriff's Office and your jails.
2. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

E. Additional Comments are Solicited

1. Please make any additional comments you have with regard to the mentally ill population and the county jail system.
2. List the name/position and phone number of the person(s) that may be consulted to answer any follow-up questions regarding your responses to this section of the questionnaire.

Leon County Sheriff's Office

Summary of
Three most Recent Jail Death Investigations

LCSO Case 04-227822. On 31 October 2004 inmate Steven Tomiano w/m DOB 8-14-72 was found hanging by a sheet in his cell. He had been in jail on a drug charge since 12 Sept. 2004. Tomiano was from Connecticut and had previously been in prison for armed robbery. Investigation found no foul play. Death was ruled asphyxia due to hanging.

LCSO Case 03-98930. On 12 June 2003 inmate Clyde Fuller b/m DOB 2-15-77 was found deceased in the Medical Unit of the jail. Fuller would not cooperate with the intake process and began screaming and spitting at staff members. He was sprayed with pepper spray and placed in a restraint chair. He later was found deceased. An autopsy discovered the following, cocaine toxicity, myocardial hypertrophy and intramuscular coronary artery with associated ischemic changes.

LCSO Case 03-82193. On 16 May 2003, inmate Ruth Hubbs w/f DOB 9-10-63 was found deceased in the jail Medical Unit. Inmate Hubbs had been acting strange and by some accounts appeared to be over-medicated. The autopsy findings indicated inmate Hubbs suffered from Doxepin intoxication. Doxepin was one of the drugs inmate Hubbs was taking in the jail. Subsequent investigation was unable to determine whether Ms. Hubbs secretly stored pills (cheeking) and possibly took an overdose or whether medical personnel over-medicated her.

Attachment # 4
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LEON COUNTY SHERIFF'S OFFICE
OFFENSE/INCIDENT REPORT (SHORT FORM)

Reported: AGENCY ORI # 370000 | JUVENILE: NO | ORIGINAL 1 / SUPPLEMENT 2: 1 | INCIDENT REPORT #: 04227822

DAY	DATE	TIME	DISPATCHED	ARRIVED	COMPLETED	OCCURRED DATE	TIME	TO	TIME
Sunday	10-31-04	1942	1942	1942	2156	10-31-04	1815	10-31-04	1816

EVENT

	Type	OFFENSE	A/C	STATUTE			UCR
1	6	Death Investigation		999	99		
2	Type	OFFENSE	A/C	STATUTE			UCR
3	Type	OFFENSE	A/C	STATUTE			UCR

INCIDENT LOCATION: Leon County Jail 535 Appleyard Drive — TALLAHASSEE, FL — ZIP: 32304 — GEO: 8-16 — TL/LC: TC

AREA IDENTIFIER / NAME OF BUSINESS / NEIGHBORHOOD, ETC.: Pod A Room 43 — F.E.: 0 — OCC.: 1 — LOCATION: 19 — WEAP TYPE: 99 — #OFFENSES: 1 — #VICTIMS: 1 — OFFENDERS: 0 — #PREM ENTERED: 0 — #VEH STOLEN: 0

PERSON

OFF #	VWS #	TYPE	NAME (Last, First, Middle)	HOME PHONE
1	V1	3	TOMIANO, Steven SPN #169564	N/A

ADDRESS: ☐ SAI: 1310 Bird Lane Tallahassee FLA. — ARRESTED? ☐ YES ☐ NO — ALT. CONTACT PHONE (REQUIRED)

ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS) — D.L. / SSN / (SPN): 169564

RACE	SEX	DOB	R.T.	R.S.	EOI	INJ. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS
W	M	8-14-72	1	1	3	99	00	604	170	Brn	Brn	

PERSON

OFF #	VWS #	TYPE	NAME (Last, First, Middle)	HOME PHONE

ADDRESS: ☐ SAI — ARRESTED: ☐ YES ☐ NO — ALT. CONTACT PHONE (REQUIRED)

ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS) — D.L. / SSN / SPN

RACE	SEX	DOB	R.T.	R.S.	EOI	INJ. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS

PERSON

OFF #	VWS #	TYPE	NAME (Last, First, Middle)	HOME PHONE

ADDRESS: ☐ SAI — ARRESTED: ☐ YES ☐ NO — ALT. CONTACT PHONE (REQUIRED)

ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS) — D.L. / SSN / SPN

RACE	SEX	DOB	R.T.	R.S.	EOI	INJ. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS

VEH

VWS #	VH #	STAT	DMG	TYPE	YEAR	MAKE	MODEL	STYLE	TAG

STATE	COLOR	VIN / HULL / FAA	RC	HOLD	NCIC / PCIC

VALUE	OWNER	REC. DATE	REC. VALUE	TOWED BY
$			$	

PROPERTY

VWS #	ITEM #	STAT.	DMG	TYPE	QTY/UNITS	NAME	BRAND	MODEL	DRUG	ACT.

SERIAL NUMBER	OWNER APPLIED NUMBER	DESCRIPTION	DRUG TYPE

VALUE	VALUE RECOVERED	DATE RECOVERED	NCIC/PCIC ENTERED (Y/N) BY WHOM:
$	$		

PROPERTY

VWS #	ITEM #	STAT.	DMG	TYPE	QTY/UNITS	NAME	BRAND	MODEL	DRUG	ACT.

SERIAL NUMBER	OWNER APPLIED NUMBER	DESCRIPTION	DRUG TYPE

VALUE	VALUE RECOVERED	DATE RECOVERED	NCIC/PCIC ENTERED (Y/N) BY WHOM:
$	$		

SEE ATTACHMENTS

CASE NUMBER: 04227822

ADMIN

DEPUTY REPORTING / WITNESSING	I.D. NUMBER	UNIT	DATE	RELATED CASE NUMBER
Patricia Hayes	471	Jail	10-31-04	

SUPERVISOR REVIEWING	I.D. NUMBER	ROUTED TO:	REFERRED TO:	ASSIGNED TO:	BY:	DATE:	PAGE	OF	PAGE
Lt. Bill Lawhon	103	10-31-04					1	OF	2

STATUS: Closed	CLEARANCE	ADULT / JUVENILE		DATE CLEARED	ARREST NUMBER	NUMBER ARRESTED	EXCEPTION TYPE	OBTS NUMBER

#23095 (04/27/04)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	NO	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	10 | 31 | 04	INCIDENT REPORT #	0 | 4 | 2 | 2 | 7 | 8 | 2 | 2

On 31 Oct 2004, at approximately 1815 hours, I officer Booker #544 responded to pod A, after hearing from Central Control over the all page, that all avilable officers needed to be in route to pod A. As I arrived into pod A, Sgt. Parrmore #103 told me to get the camera out of Central control. After returning with the camera, I began videoing the incident that occured in pod A, room number 43, which inmate Tomiano, Steven #169564 was housed in. After approximately 20mins of videoing the incident Sgt. Parrmore #103 told me to give the camera to Officer White and to return to my pod.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID #_____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Gary Booker / Gary Booker	544	10-31-04	1	OF 1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
Sgt Bill Parrmore	103	10-31-04		

FMF (1M97)

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: ~~Supplemental~~ ~~Juvenile~~

Agency Report Number: 04-227822 Victim Name(s): Tomiano, Steven P. Date Reported: 10-31-04

Officer Reporting: Donnie Jacobs ID#: 321 Date: 11-01-04

Officer Reviewing: [illegible] ID#: 137 Date: 11-5-04

Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 Oct 04, at 1910 hours, I was notified in reference to a death investigation at the Leon County Jail. Upon my arrival, I met Detective Dawn Butler, who said that Mr. Steven Peter Tamiano appeared to have hung himself in his jail cell. Detective Pat Lyons also responded to assist with the investigation.

SCENE

Pod A, Cell number 43. Mr. Tamiano had already been transported to the emergency room at Tallahassee Memorial Hospital when I arrived. I found the cell to be littered with materials used by the medical responders, in an effort to revive Mr. Tamiano. A sheet was tied around the shelf in the cell, but was cut off and taken from around his neck. I video taped and photographed the scene, and collected a video shot by Jail personnel at the time of the discovery. Mr. Tomiano's personal papers taken from a storage tub under his bunk. I then responded to the hospital and took photographs of the deceased. The body was placed in a body bag and sealed, then placed in the morgue.

ADDITIONAL INFORMATION

The autopsy was scheduled for 0900 hours, 01 Nov 04. Detective Butler and I attended. The medical examiner, Dr. Sgan, noted the ligature marks around the victims neck, and internal bruises. I took additional photographs that were added to the case file. Mr. Tomaino's clothing was seized, which included his shirt, pants, socks and wristband.

EVIDENCE

1) Portion of sheet taken from shelf
2) Portion of sheet taken from floor
3) Personal papers taken from storage tub under bunk
4)Video shot by Jail personnel
5) Crime Scene Video
6) Clothing taken from autopsy, to include shirt, pants, socks, and wristband.

DISPOSITION RECOMMENDED

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: **04-227822** Victim Name(s): **Tomaino, Steven** Date Reported: **10-31-04**

Officer Reporting: **Butler** ID#: **327** Date: **11-04-04**
Officer Reviewing: _____ ID#: 117 Date: 11-15-04
Offense(s): **Death Investigation**

Case Status: 1 UCR Clearance: 3 Date Cleared: 11/15/04 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Sunday 31 October 2004 at approximately 1920 hours I responded to the jail in reference to a death investigation. I was advised that an inmate hung himself inside his cell. The inmate was transported to TMH but, was not expected to live. Upon arrival contact was made with Sgt. Parramore, Lt. Taylor, and Lt. Mckissack. I was advised that inmate Steven Tomiano was last seen alive at 1750 hours locked down in his cell by Officer Harris. At approximately 1804 hours the inmates doors were cycled for feed up. Officer Harris noticed that inmate Tomiano did not exit his room for his food tray. She attempted to call him on his intercom but, he did not respond. At approximately 1815 hours she sent Inmate Thomas Davis to ask inmate Tomiano if he was going to eat. Inmate Davis approached the door, pushed it open and told Officer Harris that inmate Tomiano looked dead. Officer Harris responded to Tomiano's cell at which time she observed Tomiano with a sheet tied around his neck and a shelf on the wall. She called for assistance and medical. She then locked the pod down. At approximately 1816 hours medical staff and Sgt. Parramore arrived. At 1828 hours EMS arrived on scene. At 1845 hours Inmate Tomiano was transported to Tallahassee Memorial. Officer Harris advised this writer that no one went in or out of Tomiano's cell between 1804 hours when she rolled the doors and 1815 hours when Inmate Davis found him deceased. She further advised that she is not aware of any problems that Tomiano was having while there. He was booked into the jail on 12 September 2004 by TPD. He was charged with possession of cocaine and evidence tampering. He was being held on a $2,500.00 bond. Jail phone records revealed that Tomiano only attempted to make one phone call while incarcerated. That call was unsuccessful. Written statements were obtained from Officer Harris, Inmate Davis, Sgt. Parramore, Officer White, Officer King, Officer Booker, R.N. Delaney, RMA Lane, RMA Bratcher, and paramedic O'Neal.

Inmate Tomiano was pronounced dead by Dr. Jusina at approximately 1915 hours. Detective D. Jacobs photographed the scene, collected evidence, and attended the autopsy. (See his continuation) I observed cell #43 which is a double bunk cell. There were numerous articles of medical nature on the floor. I observed a white bed sheet tied on to a shelf on the wall. The sheet appeared to be cut. The other section of sheet was located on the floor of the cell. A search of the cell for a suicide note met with negative results. Inmate Tomiano's personal information sheet listed his parents as deceased with no contact information for the next of kin.

At approximately 2134 hours Detective Jacobs and I responded to TMHER at which time we made contact with Officer King. Inmate Tomiano's neck injury was photographed by Detective Jacobs. After observing his body we found no signs of foul play. Rigor Mortis was not present at the time of our investigation. He was secured in a body bag and transported to the morgue. This writer made contact with on-call medical examiner Dr. Sgan. He advised that he would perform an autopsy on 01 November 2004 at 0900 hours.

On 01 November 2004 I attended the autopsy. A visual inspection of the body revealed no injuries other than linear bruising to his neck consistent with hanging. The hyoid bone was still intact. The autopsy revealed that one of Tomiano's kidneys and spleen had been surgically removed in the past. There were no signs of foul play.

On 01 November 2004 at 1213 hours I contacted Tomiano's mother Patricia Tomaino in Niantic, Connecticut. She advised that she has not seen or heard from her son for over 10 years. She stated that he was last known to be in prison in North Carolina for an armed robbery. She advised that during the robbery he was shot by police and that is

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 04-227822 Victim Name(s): **Tomaino, Steven** Date Reported: **10-31-04**

how he lost his kidney and spleen. At her request I made arrangements for his property to be sent to her in Connecticut. While speaking to her I became aware that his last name is spelled Tomaino instead of Tomiano that he was booked in under. His drivers license and criminal history were also under Tomaino.

On 02 November 2004 I received two written statements from Lt. Taylor. The statements were authored by inmate Allen Paris and inmate William Edenfield. Mr. Edenfield made allegations that Officer Harris did not complete her rounds as she stated in her report. Inmate Paris made statements that he has seen the deceased in a private conversation with an inmate occupying cell #26. These statements do not alter or affect the criminal investigation in any way however; they may affect the administrative investigation. I advised Detective McBride of these statements.

This death investigation has been determined to be suicide by hanging with no evidence of foul play.

DISPOSITION RECOMMENDED

Exceptionally Cleared

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Yes Supplemental: No Juvenile: No

Agency Report Number: **04227822** Victim Name(s): **Tomiano, Steven** Date Reported: **10-31-2004**

Officer Reporting: Patricia Harris **Patricia Harris** ID#: **471** Date: **10-31-2004**
Officer Reviewing: **B. W Parramore** ID#: **103** Date: **10-31-04**
Offense(s): **Death Investigation**

Case Status: _____ UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

I was assigned to Pod A on the 1700 to 0500 shift on 31 October 2004. After assuming duties, I completed a Visual Inspection at 1750 hours of all inmates. All inmates appeared to be resting or waiting to eat. I started feed up at 1804 hours and completed at 1811 hours. I noticed that Inmate Steven Tomiano #169564 had not eaten. I attempted to call him on the intercom but did not hear a response. I then asked Inmate Thomas Davis #593 who was assisting with feed up to go and ask the inmate in room 43 if he was going to eat. Inmate Davis went to room 43, he then called me over to room 43. I went to room 43 and saw Inmate Tomiano with a sheet tied around his neck and around the shelf. He was sitting on the floor and appeared to have hung himself. I called for assistance and medical on the radio, I then ordered the pod to lock down. At 1815 hours, Nurses Bob Delaney, Michelle Lane, Kathy Bratcher and Sergeant Bill Parramore arrived. Emergency personnel arrived from the Fire Department and Ambulance Service at 1828 hours. Inmate Tomiano was taken out of Pod A on a stretcher at 1845 hours. "See Nurses Inmate Progress Report"

During my tour of duty in Pod A, I did not see anyone go into room 43 and I did not have any problems with Inmate Tomiano.

See Attachments
Supplements from Sergeant Bill Parramore, Officers Kevin White, Clete King, and Garry Booker.
See documentation from Nurses Bob Delany, Kathy Bratcher, Michelle Lane and Travis Oneal
See Sworn Affidavit from Inmate Thomas Davis #593
Leon County Sheriff's Officer Property Receipt

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Yes Supplemental: No Juvenile: No

Agency Report Number: **04227822** Victim Name(s): **Tomiano, Steven** Date Reported: **10-31-2004**

Officer Reporting: Sergeant Bill Parramore ID#: **103** Date: **10-31-2004**
Officer Reviewing: Diana Sheffield ID#: 127 Date: Oct. 31, 04
Offense(s): **Death Investigation**

Case Status: _____ UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 October 2004, at approximately 1815 hours, I responded to Pod A because of a call for assistance. I arrived at the same time as Charge Nurse Bob Delaney, and Nurses Kathy Bratcher and Michelle Lane. As soon as we entered Pod A Room 43, I observed Inmate Steven Tomiano #169564 in a sitting position with one end of a sheet tied around his neck. The other end of the sheet was tied around the towel rack. Inmate Tomiano was unresponsive and his body was limp. As medical personnel cut the sheet and started treatment, I sent officer Gary Booker to get a video camera. I then instructed Central Control to call for an ambulance at the request of Nurse Delaney. At approximately 1817 hours, Officer Booker returned with the video camera and started recording this incident. I then instructed Officer Gene Wood in Central Control to call Captain Kim Petersen and advise her of this incident. At approximately 1830 hours, members of the Tallahassee Fire Department and Leon County Ambulance Service arrived and started treating Inmate Tomiano. The Ambulance departed with Inmate Tomiano at approximately 1900 hours en route to Tallahassee Memorial Hospital. Officer Clete King was sent with Inmate Tomiano and remained until he was relieved by Detective Dawn Butler at approximately 2134 hours.

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Yes Supplemental: No
Juvenile: No

Agency Report Number: **04-227822** Victim Name(s): **Tomiano, Steven** Date Reported: **10-31-2004**

Officer Reporting: **Officer Kevin White** ID#: **475** Date: **10-31-2004**
Officer Reviewing: Sgt M. Abe 113 Thomas Stge ID#: 113 Date: _____
Offense(s): **Death Investigation**

Case Status: _____ UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On the above date at approximately 1815 hours, I responded to Pod A due to a call for assistance. Upon arrival I observed Nurses Michelle Lane, Bob Delaney, and Kathrine Bratcher preforming CPR on inmate Tomiano, Steven Spn# 169564 in cell 43. I assisted by obtaining the oxygen bottle from Medical and delivered it to the Medical Staff. At approximately 1840 hours, I was instructed by Sergeant William Parramore to take over the video camera from Officer Gary Booker. I continued to film the incident until approximately 1850 hours, when inmate Steven Tomiano was placed in the ambulance and the doors were secured.

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Original: yes Supplemental: no Juvenile: no

Agency Report Number: 04-227822 Victim Name(s): Tomiano, Steven
Date Reported: 10-31-2004

Officer Reporting: Clete King ID#: 400 Date: 10-31-2004
Officer Reviewing: Sgt Bill Parramore ID#: 103 Date: _____
Offense(s): Death Investigation

Case Status: _____ UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 October 04 at approximately 1850 hours, I was instructed by Sergeant Stege #113 to follow the ambulance containing Inmate Tomiano, Steven Spin # 169564 to Tallahassee Memorial Hospital 10-18. I arrived at TMH at approximately 1911 hours and followed EMS into the Emergency Room. At approximately 1914 Inmate Tomiano was seen by Doctor Jusino and pronounced dead at approximately 1915. I then secured the room as a crime scene and remained with Inmate Tomiano until relieved by Detective Dawn Butler at approximately 2134 hours.

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE

OFFICE OF INTERNAL AFFAIRS REPORTING FORM

AIB CASE NO: A04-101A

DATE RECEIVED COMPLAINT: 31 October 2004

DATE REPORT COMPLETED: 19 November 2004

COMPLAINANT: Capt. Karen Bodiford

MEMBER INVOLVED: C.O. Patricia Harris

INVESTIGATOR: Det. Melinda McBride
Office of Internal Affairs

DISCIPLINARY STANDARD

042-A Standard of Conduct/Integrity - Gross Violation : Employees shall not engage in any conduct that constitutes a gross violation of conduct unbecoming an officer, or any act that is likely to severely affect the discipline, good order, or reputation of the agency, or that will compromise the integrity of the employee. Employees shall refrain from any conduct that grossly detracts from or severely affects public faith and trust in the agency, i.e., being arrested for committing a felony, or a misdemeanor involving dishonesty, perjury, a false statement or an immoral act and such arrest being sustained by an administrative investigation. Employees shall comply with the Cannon of Ethics as found in General Order 1.2 *(Level Five Violation)*.

SYNOPSIS OF COMPLAINT

It is alleged that Officer Patricia Harris failed to do a visual check/count of inmates upon arriving on duty and relieving the off going officer in pod A on 31 October 2004 at 1650 hours. It's alleged that she falsified the official pod log book by logging that she did a visual check/count at 1650 hours and another at 1750 hours. At or around 1813 hours it was discovered that an inmate in that pod (room 43) had hung himself. That death investigation was conducted by the LCSO Violent Crimes Unit Det. Butler.

INVESTIGATIVE NARRATIVE

On 31 October 2004 I responded to the Leon County Jail (Pod A), in reference to an inmate hanging himself. Upon arrival, LCSO Violent Crimes Unit Det. Dawn Butler and Lt. Todd McKissack, along with Crime Scene Detectives Donnie Jacobs and Pat Lyons were on scene. Also present was the jail staff Sgt. Parramore, Lt. Taylor, and C.O. Patricia Harris, who was assigned to pod A for the evening shift (1700-0500). Inmate Steven Tomiano (SPN# 169564) had already been transported by EMS to Tallahassee Memorial Hospital, where he was later pronounced dead at 1915 hours by Dr. Jusina. Det. Dawn Butler was assigned to conduct the death investigation (case #04-227822)

A review of the scene was conducted upon my arrival to the jail and I observed a bed sheet tied around a metal rack/towel hanger in room #43 that appeared to have been cut. The other part of the sheet was on the floor. I also observed numerous empty packages from medical supplies that were left by the jail medical staff and EMS. I also viewed the pod log which showed that Ofc. Harris had done visual checks of the inmates at 1650 hours and 1750 hours. A copy of the log book for the is included in this case.

A copy of the Offense/Incident Report - Death Investigation by Det. Butler is included in this file. It includes the reported chain of events surrounding this incident to include the autopsy, as well as information gathered about Inmate Tomiano's history. Det. Butler completed her investigation and the case was closed exceptionally cleared. She noted that this investigation had been determined to be suicide by hanging with no evidence of foul play.

During this investigation I was notified that two inmates, William Edenfield (SPN# 99763) and Allan Paris (SPN#23862), had written sworn affidavits in reference to this incident. Also, Inmate Michael Robbins (SPN# 84854) had written a request to speak to the Chaplain about Inmate Tomiano. A copy of the statements and request are included in this file.

Inmate Edenfield's statement alleged that Officer Harris never made her rounds when she relieved Officer Williams on 31 Oct. 2004. Inmate Edenfield was released from jail before receipt of his statement. Therefore, he was not interviewed.

Inmate Paris' statement referenced several inmates having conversations and was not specifically related to this incident. He was not interviewed.

On 05 November 2004 I conducted a tape recorded interview with Inmate Michael Robbins, after he was advised of and signed a Confidentiality Notice. Inmate Robbins had written a request to speak with the chaplain about Inmate Tomiano. Inmate Robbins advised that as far as Inmate Tomiano's death, he was 100% shocked that it happened. He stated that the day of his death, he had been talking to him and Inmate Tomiano seemed to be in good spirits and he was calm. He added that they also talked about trading some canteen items that they were preparing to order, which they discussed right at lock down at 1610 hours. Inmate Robbins advised that Inmate Tomiano had previously told him that he was somewhat depressed about his current charges and the issue of him being on parole from another state. However, he did not seem to be depressed to the point of committing suicide and he never made any comments about suicide. Inmate Robbins said that Inmate Tomiano had filled out several request, two or three of them he actually saw him fill out because he lent him a pencil to do so, to go to medical and talk to someone about him feeling depressed. He noted that he doesn't know whatever happened to the request. Inmate Robbins did advise that he was aware that Inmate Tomiano went to medical several times for treatment due to a spider bite and he told him to just talk to them then about his depression.

Inmate Robbins stated that Ofc. Stephon Williams was on the day shift and he was relieved by Ofc. Patricia Harris. He went on to say that the pod (A) was permitted outside on the incident date. They came in around 1600 hours and the pod was locked down around 1610 hours. He said that he recalls Officer Williams doing a visual check right after lock down. Inmate Robbins said that when Officer Harris came on duty she did not do a visual check of the inmates. He said that she sat at the officer's desk and ate something and watched television. He advised that she never did a visual check up until Inmate Tomiano was discovered, which was by the inmate assisting with feed up. He said that he knows she didn't do a visual check because he stays by his door looking out. Inmate Robbins also advised that Inmate Tomiano talked to another inmate named Scott, who was housed in room 41. He noted that other than the two of them, Inmate Tomiano didn't really talk to anyone else.

*** End of Statement ***

On 08 November 2004 I conducted a tape recorded interview with Inmate Scott Collins (SPN#150417), after he was advised of and signed a Confidentiality Notice. Inmate Collins advised that he had been talking with Inmate Tomiano, who on the day of this incident told him that he would come to his (Inmate Collins) ministry program when released. He advised that they talked outside that day and being that their rooms were next to each other they spoke every day. Inmate Collins relayed that he does recall Inmate Tomiano asking officer's several times to go to medical. He noted that Inmate Tomiano had a spider bite that he was being treat

for. He stated that he observed Inmate Tomiano write a medical request, but he could not advise what he did with it. Inmate Collins also advised that to best of his recollection Officer Harris did not do a visual check of the inmates when she came on duty. He added that until this incident most of the officers didn't do visual checks. *** End of Statement ***

On 08 November 2004 I conducted a tape recorded interview with Correctional Officer Stephon Williams, after he was advised of and signed a Confidentiality Notice. Officer Williams worked pod A on the day shift on 31 October 2004 and he was relieved by Officer Harris at or around 1645 hours.

Officer Williams advised that he took the inmates outside that day. They came in for lock down at 1600 hours and he conducted a visual check of the inmates at 1608 hours. Ofc. Williams said at that time all inmates, including Inmate Tomiano, were reading, writing, or resting on their bunks. He advised that was the last visual he conducted. Officer Harris came in the pod at 1645 hours and he turned over all equipment, etc. to her. Officer Williams advised that Officer Harris ***did not*** conduct a visual/count of the inmates at the time she relieved him or prior to him leaving the pod. He clarified advising that means she did not go around the pod and do a visual check/count of the inmates. He stated that they talked for a brief moment, she signed off on the log (noting that she did a visual check/count), and told him she had to make a phone call. He left and she went to the bathroom.

Officer Williams was asked if he was aware of Inmate Tomiano having put in any request for medical. He could not advise if Inmate Tomiano had or had not. He stated that he usually gives the inmates back their medical request to give directly to the nurse when he or she makes rounds in the pod, because medical prefers that being that the nurse has to sign off on them.

*** End of Statement ***

On 09 November 2004 I served Officer Patricia Harris with a Notification of Administrative Investigation. I also conducted a tape recorded interview with her after all applicable notices were given and signed. Ofc. Harris was advised that during the Administrative Review/Investigation of the death of Inmate Tomiano, allegations came forth from inmates that she did not conduct a visual check/count of the inmates when she relieved Ofc. Williams on 31 October 2004.

Ofc. Harris first asked how would we know if she did a visual check or not. As I began to inform her how the allegations came forth, she interjected answering in question form "the inmates". I advised her that this information came from the inmates and Ofc. Williams was also interviewed. I informed her that Ofc. Williams attested to what took place upon her relieving him, until he left the pod and he said that she did not do the visual check/count during that time. Ofc. Harris then said that she didn't do the visual while he was there. She added that usually no one does the

visual when relieving, it's done afterwards. I then showed her the log book for pod A, confirming that the entries referenced where made by her. I referred to the entry she made at 1650 hours stating that she did a visual check. She was asked if she did the visual as she logged in the book and she said "no". She was then asked if she did the visual check at 1750 hours that she logged. She thought for a moment and said that she probably didn't do that one either. Officer Harris then said "because I be doing so much stuff until it just, you can't really, if I get to it I get to, I mean sometimes I can't sometimes I can". She was asked if procedure was to conduct these checks every hour and she "no, I walk around every-whenever, not every hour but like 40-50 minutes or something like that". She confirmed that she did not do the checks as she logged in the log book at 1650 hours and 1750 hours. She was asked for any explanation and she said she was preparing for feed up with an inmate assisting her.

Ofc. Harris advised that when she finished feed up, Inmate Tomiano didn't come to get his food. She had the inmate assisting with feed up go to his room door to ask if he was going to eat. That's when it was discovered that Inmate Tomiano had hung himself. At that time she locked the pod down, notified medical and supervisors.

I asked Ofc. Harris if she had actually done the visual checks that she logged during the shift other than the two noted and she said that she did. Both of the visual checks Ofc. Harris logged, but admits she did not do, were prior to discovering that Inmate Tomiano had hung himself.

Ofc. Harris was again asked if there was any explanation that she would like to give in her defense and she said no.

I also asked her if she recalled Inmate Tomiano giving her any sick call forms. She said he had not and usually when inmates write up sick calls they keep them to give directly to the nurse.

*** End of Statement ***

Contact was made with the medical staff and a copy of Inmate Tomiano's medical file was obtained. The file was secured by the medical staff administrator, Ms. Leticia Wright. In reviewing the file, Inmate Tomiano had in fact put in three sick call requests for a foot fungus, spider bite, and for the release of his medical status for trustee duty. Inmate Tomiano was being treatment for the foot fungus and spider bite. There were no other medical issues or requests in his file. Ms. Wright also stated that there were no indications that Inmate Tomiano was considering suicide.

I obtained the log book for pod A and made copies of the entries for the day and evening shift on 31 October 2004. I also reviewed Inmate Tomiano's inmate file and found that he had not reported any problems and he had not been disciplined for any reason. I did find that he was actively seeking to become a trustee. The pod log indicates that Officer Williams conducted a

visual inspection of the inmates at 1608 hours and completely locked the pod down at 1630 hours after clean up. At 1650 hours, Office Harris came on duty and logged a visual check and the receipt of the keys, radio, etc. She also logged a visual check of inmates at 1750 hours.

Also, obtained was the door activity for room 43 on 31 Oct. 2004. As it relates to the discovery of Inmate Tomiano, it shows that at 18:07:00 hours his door was unlocked. This would have been for feed up. Prior to that it had been locked since lock down at 1600 hours. At 18:13:21 hours the intercom was activated by the officer calling the inmate. At 18:14:21 the door was opened. This was when it was discovered that he had hung himself.

Officer Harris also documented an Offense/Incident Report titled Death Investigation. Attached to her report are the continuations from all responding personnel, including medical personnel. A statement from Inmate Thomas Davis (SPN# 593) was also included. He was the inmate assisting with feed up and who discovered Inmate Tomiano, after Officer Harris sent him to Inmate Tomiano's room door to see if he was going to eat. It should be noted that Ofc. Harris also wrote in her report that she completed a visual inspection at 1750 hours of all inmates.

CONCLUSION

During this investigation statements were gathered from Inmates William Edenfield (written only), Michael Robbins, and Scott Collins alleging that Officer Harris did not conduct the visual check/count of inmates when she arrived on duty. A statement was also obtained from Ofc. Williams, who Ofc. Harris relieved, advising that he too did not observe Ofc. Harris conduct a visual check/count upon her arrival or before he left the pod. Ofc. Harris also admitted in her own interview that she ***did not*** conduct the visual checks that she logged in the official pod log book for pod A on 31 Oct. 2004 at 1650 hours and 1750 hours.

Based on this information and Ofc. Harris' own admission, she willfully neglected her job duties and she knowingly made a false statement in writing (log book and offense/incident report), thus falsifying an official record. This conduct constitutes a gross violation of conduct unbecoming an officer, it compromises the integrity of an officer, and it severely affects the reputation of this agency. Initially Ofc. Harris was served notification with the charges' Untruthfulness Not in an Official Proceeding and Willful Neglect of Job Duties. *However, this conduct supports a sustained finding for Standard of Conduct/Integrity - Gross Violation.*

FINDINGS

042-A Standard of Conduct/Integrity - Gross Violation - Sustained

ATTACHMENTS

1) Notification of Administrative Investigation (Ofc. P. Harris)
2) Notice of Agency Policy Violation (Ofc. P. Harris)
3) Employee Rights Interview (Ofc. P. Harris)
4) Confidentiality Notice (Ofc. P. Harris)
5) Confidentiality Notice (Ofc. S. Williams)
6) Confidentiality Notices (Inmates Michael Robbins, Scott Collins)
7) Written sworn affidavits (Inmate William Edenfield, Allen Paris)
8) Copy of inmate request from Inmate Robbins
9) Copy of pod A log for 31 Oct. 2004 (both day/night shifts)
10) Copy of Inmate Tomiano's medical file.
11) Copy of Death Investigation report written by Ofc. Harris
12) Email from Sam Adams ref: Pod A, Room 43 door activity
13) Copy of video tape of incident after discovery
14) Copy of scene photographs
15) Copy of LCSO Death Investigation Report (case #04-227822)
16) Cassette tape recorded interviews (Inmate Robbins, Inmate Collins)
17) Cassette tape recorded interview (Ofc. S. Williams)
18) Cassette tape recorded interview (Ofc. P. Harris)
19) Investigative Findings Form
20) Prior Discipline Worksheet
21) Disciplinary Recommendation Form

PRESS HARD — YOU ARE MAKING 4 COPIES

LEON COUNTY SHERIFF'S OFFICE
OFFENSE/INCIDENT REPORT (SHORT FORM)

AGENCY ORI #370000 | JUVENILE | ORIGINAL 1 / SUPPLEMENT 2: 1 | INCIDENT REPORT #: 03098923

EVENT

REPORTED DAY	DATE	TIME	DISPATCHED	ARRIVED	COMPLETED	OCCURRED DATE	TIME	TO DATE	TIME
THU	6 12 03	0417	0417	0417	0418	6 12 03	0400	6 12 03	0500

OFF #	TYPE	OFFENSE	A/C	STATUTE
1	3	RESISTING O.C. FOAM	C	843.02
2	9	DEATH INVESTIGATION		999.9999

INCIDENT LOCATION: 535 APPLEYARD DR. TALLAHASSEE ZIP 32304 GEO 816 TL/LC TL

AREA IDENTIFIER: LEON COUNTY JAIL

F.E.	OCC.	LOCATION	WEAP. TYPE	# OFFENSES	# VICTIMS	# OFFENDERS	# PREM. ENT.	# VEH. STOLEN
0	0	19	00	02	00	01	00	00

PERSON

OFF #: 1 | V.W.S #: 20 | SI: 3 | NAME: FULLER, CLYDE SPN# 109820 | HOME PHONE: (850) 222-1235

ADDRESS: 1809 SAXON ST. TALLAHASSEE FL. 32301

ADDITIONAL DESCRIPTION/ALT. CONTACT:

RACE	SEX	DOB	R.T.	R.S.	EOI	INJ. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS
B	M	2/15/7?	2	2	9	99	00	5'8"	170	BROWN	BLACK	

(SEE ATTACHED)

ADMIN

OFFICER REPORTING: Sgt. Terry Fryar 105 | ID NUMBER: Terry Fryar 105 | DATE: 6-12-03

OFFICER REVIEWING: Lt. Howard [illegible] / Larry Campbell

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 / SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT #
		1	06/12/03	03098923

On 6-12-2003 inmate Clyde Fuller was transported to the Jail at 0150 hours. At 0336 hours he was booked into the Jail and process and Showered. At 0345 hours nurse Debra Linton was unable to screen inmate Clyde Fuller in booking due to him talking to himself. At 0355 hours inmate Clyde Fuller was escorted to medical by officer Craig Carroll and myself because the charge nurse McCabe wanted to evaluate inmate Clyde Fuller in medical. Nurse McCabe wanted inmate Fuller placed in a paper gown and in room #515 under direct supervision. myself and officer Craig Carroll started to escort inmate Fuller to his cell when he became combative and he was restrained on the floor by myself and officer Craig Carroll. Officer James Morgan arrived to assist in restraining inmate Fuller. Inmate Fuller continued to resist so officer James morgan sprayed inmate Fuller with OC foam in the facial area. At that point inmate Fuller was secured with handcuff and leg shackles and nurse McCabe ordered that inmate Fuller be placed in the restraint chair due to his management behavior. At 0400 hours inmate Clyde Fuller was placed in the restraint chair by myself, officer Chris Bryant, and officer Charles Johnson. ONCE inmate Fuller was placed in the restraint chair nurse McCabe gave inmate Fuller a shot and he became calm and he was placed in room #515 on direct observation. At 0423 hours officer William Summerlin called for assistance down at medical direct. When I arrived nurse McCabe informed me that inmate Fuller had a week pulse and low breathing. officer Georgia Woerner began CPR on Inmate Fuller.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
Sgt. Terry Fryar Sgt Terry Fryar	105	6-12-03	2 OF 3
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE	

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE		ORIGINAL - 1 SUPPLEMENT - 2	)	REPORTED DATE	6 | 12 | 03	INCIDENT REPORT #	0 | 3 | 0 | 9 | 8 | 9 | 2 | 3

EMS was called by Nurse Debra Linton and they arrived at 0437 hours (Paramedic Scott Hill and George Azar). At 0500 hours I called Captain Mills, Major Bennett, Captain Bodiford, Lieutenant Taylor, Lieutenant Butler, and Dispatch. Dispatch called the on call persons Investigator. NO officer were insured during the incident

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID #_____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Sgt. Jerry Fryar Terry Fryar 105	105	6-12-03	3 OF	3
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6 12 03	INCIDENT REPORT #	03098923

On 12 June 2003, at approximately 0400 hours, I responded to a Call for assistance in medical. When I arrived on scene, Sergeant Fryar and two other Officers had a inmate restrained on the floor. The inmate was identified to me as Fullers, Clyde spn 109820. Fuller was spitting, Cussing and attempting to get away from the Officers restraing him. Sergeant Fryar ordered me to hold a towel over inmate Fullers face while we placed him in the restraint chair, to keep him from spitting on the officers. I then assisted in placing the inmates left leg in restraints While a Officer held the towel over his face. I then helped restrain his upper torso while officers restrained inmate fuller arms. I did this by placing my left hand on his Chest. Once inmate Fuller was secure and placed in holding Cell 1-515 I returned to booking.

At approximately 0420 hours on this same day, I again responded to another Call for assistance in medical for inmate Fuller. Upon arriving in medical I observed Nurse Mccabe and nurse Bratcher in holding Cell 1-515 with inmate Fuller. Nurse Mccabe advised that inmate Fuller was not breathing properly and had a very low Pulse rate. The nurse stated that the inmate had gone into arrest. At this time I started removing the restraint straps OFF OF inmate Fuller So C.P.R. Could be better administered Once inmate fuller was unsecured I assisted in placing him on his bunk so C.P.R Could be Conducted in a better manner. Once inmate Fuller was placed on his bunk I held his neck in a manner to give proper airflow I exited Inmate Fullers room when the E.m.s. Puramedics arrived and took over.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

Certifying Officer

___ Personally Known ___ Identified By ID # _____

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Chris Clymer	327	12 June 2003		OF
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT # 03-989213

AT APPROXIMATELY 0355 HOURS ON 12 JUN 03 SERGEANT FRYER AND I WERE ESCORTING INMATE CLYDE FULLER SPN # 109820 TO MEDICAL TO BE SEEN BY THE NURSE. NURSE MCCABE ADVISED THAT THE INMATE SHOULD BE PLACED ON DIRECT. WE BEGAN ESCORTING THE INMATE TO THE BACK OF MEDICAL AND THE INMATE BEGAN TO RESIST AND SAT ON THE FLOOR. OFFICER MORGAN CAME TO ASSIST US IN MOVING THE INMATE AND THE INMATE BEGAN TO GET VIOLENT KICKING SPITTING AND TRYING TO SWING HIS ARMS. WE PLACED THE INMATE FACE DOWN ON THE FLOOR TO SECURE HIM. INMATE FULLER REFUSED TO COMPLY AND OFFICER MORGAN SPRAYED INMATE FULLER WITH O.C. FOAM. INMATE FULLER STILL WOULD NOT COMPLY. OFFICER MORGAN AND I PLACED HAND CUFFS ON INMATE FULLER AND DOUBLE LOCKED THEM. I HELPED OTHER OFFICERS PLACE INMATE FULLER INTO THE RESTRAINT CHAIR PER NURSE MCCABE. ALL RESTRAINTS WERE CHECKED AND THE INMATE WAS PLACED IN ROOM # 515 IN THE BACK OF MEDICAL AT APPROXIMATELY 0430 HOURS I RESPONDED TO A CALL FOR ASSISTANCE IN MEDICAL ON INMATE FULLER. I ENTERED ROOM 515 NURSE MCCABE AND BRATCHER

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
Craig H. Carroll	392	12 Jun 03	1 OF 2

OFFICER REVIEWING (IF APPLICABLE) ID # DATE

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL – 1 SUPPLEMENT – 2	REPORTED DATE	INCIDENT REPORT #
				03-989023

WERE PRESENT IN THE ROOM AND INMATE FULLER SEEMED TO BE UNRESPONSIVE. I ASSISTED IN REMOVING INMATE FULLER FROM THE RESTRAINT CHAIR AND PLACING HIM ON THE BED. THE NURSE AND OTHER OFFICERS STARTED CPR ON INMATE FULLER. THE EMT ARRIVED AT APPROXIMATELY 0437 HOURS. I RECEIVED THE NURSE OF THE RESUSCTATION BAG AND CONTINUED IT UNTIL INMATE FULLER WAS PRONOUNCED DEAD AT 0500 HOURS

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID #_____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
Craig H. Carroll Craig H. Carroll	392	12 June 03	2 OF 2

OFFICER REVIEWING (IF APPLICABLE) ID # DATE

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6 12 03	INCIDENT REPORT #	0 3 0 9 8 9 2 3

On 12-June-2003 at approximately 0400 hours I responded to medical, where I arrived I saw inmate Fuller, Clyde 109820 actively resisting Sgt. Friar 105 and officer Morgan 431. At this time I assisted in placing Fullers left leg in a shackle. The order was then given to place Fuller in the restraint chair, where I assisted by holding a towel over inmate Fullers face using my left trader fingers and thumb. While the restraint was being applied I also assisted by securing the pull straps in back of the chair. Inmate Fuller was then placed in room 515 in medical on direct supervision.

At approximately 0423 hrs I again responded to medical and videotaped the effort to administer CPR on inmate Fuller, Clyde.

At approximately 0500 hrs I was assigned to secure 515 until the persons investigator arrived. At no time did anyone enter the room. At 0645 hours I was relieved by officer Owens 447.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____ | Certifying Officer

___ Personally Known ___ Identified By ID # _____

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
344 David Brown	344	12-JUNE-03	1 OF	1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
Sgt. Terry Friar	105	12 JUNE 03		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6 12 03	INCIDENT REPORT #	0 3 1 0 9 1 8 1 9 1 2 3

At approximately 0420 hours, I responded to a 10-24 in medical direct, male side. Inmate Fuller, Clyde Sp# 109802 was still restrained in the pro-restraint chair that was ordered by medical due to an incident occuring 10 minutes prior. Nurses Macabe and Bratcher were examining inmate Fuller in an effort to start CPR. I assumed a position in front of inmate Fuller and began chest compressions. Ofc. C. Bryant unrestrained the inmate and the inmate was moved to the bed in order to continue CPR and other medical aid that was being administered. I continued chest compressions until the paramedics pronounced him dead at approximately 0504 hours.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING: Georgia Werner ID # 479 DATE 12 Jun 03 PAGE OF PAGE

OFFICER REVIEWING (IF APPLICABLE) Sgt Terry Fryar/OT Terry Fryar ID # 105 DATE 12 June 03

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL – 1 SUPPLEMENT – 2	1	REPORTED DATE	06/12/03	INCIDENT REPORT #	013019189213

On June 12, 2003 at approximately 0410 hours, I officer Charles Johnson #350 responded to a call for help in medical. Upon arriving in medical I observed SGT. Fryar, Ofc. Morgan and Ofc. Carol with inmate Fuller, Clyde Spin # 109820 on the floor. I assisted in placing inmate Fuller in restraint chair by securing inmate Fuller's left arm and left leg.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Charles Johnson 350	Charles Johnson 350	6/12/03		OF
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
Sgt Terry Fryar 105	Terry Fryar 105	6-12-03		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE		ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6 12 03	INCIDENT REPORT #	0 3 0 9 8 9 1 2 3

ON 12 JUNE 03 I WAS WORKING ON MEDICAL DIRECT. NURSE MCCABE ENTERED THE OCEAN AT APPROXIMATELY 0420 HRS. TO CHECK ON I/M FULLER id RM 515. SHE FOUND HIM UNRESPONSIVE, AND HAD ME CALL FOR HELP ON THE RADIO. C.P.R. WAS STARTED AND CONTINUED UNTIL 0500 HRS. AT WHICH THE INMATE WAS PRONOUNCED DEAD.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
William Summerlin	469	12 JUNE 03	1	OF 1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT #

ON 12 JUNE 03 AT APPROXIMATELY 0645 I RELIEVED DEPUTY DAVID BROWN ID#344 OF DUTIES SECURING ROOM NUMBER 1-575 MEDICAL DIRECT AREA WITH INMATE FULLER, CLYDE SPN# 109820 PRESENT.

AT APPROXIMATELY 0651 DETECTIVE STEVE WOODCOCK ID#245 ENTERS ROOM # 1-575 AND BEGINS INVESTIGATION.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
C.S. OWENS/C.S. OWENS	447	12 JUNE 03	1 OF	1

OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE
[illegible]		12

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	06/12/03	INCIDENT REPORT #	03019819213

ON 11 JUNE 2003 I WAS ASSIGNED TO THE MEDICAL UNIT OF THE LEON COUNTY JAIL ON THE 1700xx0000 SHIFT. ON 12 JUNE 2003 AT APPROXIMATELY 0400HRS AFTER COMPLETING FEED UP IN THE MALE INFIRMARY I HEARD A COMMOTION AND OBSERVED SGT. FRYAR AND CPL. CARROLL ESCORTING INMATE CLYDE FULLER SN# 180880 TOWARDS ME FROM THE BOOKING UNIT. THEY WERE WALKING BEHIND HIM GIVING VERBAL COMMANDS TO CONTINUE WALKING. HE OFFERED PASSIVE AND ACTIVE RESISTANCE ATTEMPTING TO NOT GO FORWARD AS THEY HAD THEIR HANDS ON EITHER OF HIS SHOULDERS. HE WAS ALSO CURSING AND YELLING, SOMETIMES IN AN INCOMPREHENSIBLE MANNER. UPON THE OFFICERS ENTERING THE HALLWAY WITH THE SUBJECT HE SQUATTED AND SAT ON THE FLOOR. HE CONTINUED TO RANT AND PULL AWAY FROM SGT. FRYAR AND CPL. CARROLL. SGT. FRYAR CONTINUED GIVING VERBAL COMMANDS TO STAND AND WALK ASSISTED BY CPL. CARROLL WHEN INMATE FULLER BEGAN TURNING HIS HEAD FROM SIDE TO SIDE AND SPITTING. I WALKED OVER TO ASSIST THEM BY GIVING HIM THE COMMAND TO STAND AS I GRABBED HIS LEFT ARM TO HELP HIM STAND. AS HE BEGAN TO STAND HE SUDDENLY WRITHED VIOLENTLY BY PUSHING AND PULLING AGAINST US WHILE KICKING AT THE SAME TIME. I LOST MY BALANCE TEMPORARILY AS I HELD ON TO HIS LEFT ARM AND WE WRESTLED HIM TO THE FLOOR. SGT. FRYAR ATTEMPTED TO RADIO FOR MORE ASSISTANCE. I SPRAYED HIM ABOUT THE FACE WITH APPROXIMATELY A 1 TO 2 SECOND STREAM OF O.C. SPRAY. I RESECURED MY SPRAY AND CONTINUED TO HELP CONTROL INMATE FULLER WHO AT THIS TIME WAS ON HIS STOMACH WITH HIS RIGHT ARM TUCKED UNDER HIS BODY. I ORDERED HIM TO STOP RESISTING BUT HE WOULD NOT COMPLY. HE OFFERED AN EXTRAORDINARY AMOUNT OF RESISTANCE AS IT TOOK BOTH ME AND CPL. CARROLL TO APPLY MY HANDCUFFS BEHIND HIS BACK AND DOUBLE LOCK THEM WHILE SGT. FRYAR CONTROLLED HIS HEAD TO KEEP HIM FROM SPITTING AT US. OTHER OFFICERS RESPONDED AND ASSISTED AS I PLACED SHACKLES ON HIS ANKLES AND DOUBLE LOCKED THEM. I THEN ASSISTED IN CONTROLLING INMATE FULLER'S LEFT ARM AS HE WAS SECURED IN THE RESTRAINT CHAIR. AT APPROXIMATELY 0423HRS I RESPONDED TO CPL. SUMMERLIN'S REQUEST FOR HELP TO THE DIRECT OBSERVATION ROOM #1-SIS IN THE MEDICAL UNIT WHERE HE REPORTED THAT INMATE FULLER WAS UNRESPONSIVE AT THAT TIME. WHEN I ARRIVED NURSES MCCABE AND BRATCHER WERE PRESENT ATTENDING TO INMATE FULLER. I ASSISTED OFFICERS GARROU AND WOERNER WHO ALSO RESPONDED. TOGETHER WE REMOVED INMATE FULLER FROM THE RESTRAINT CHAIR TO THE BUNK. AT NURSE BRATCHER'S REQUEST I OPERATED THE ARTIFICIAL BREATHING MASK UNTIL THE E.M.T.'S ARRIVED AND TOOK OVER.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____ | Certifying Officer

___ Personally Known ___ Identified By ID # _____

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
JAMES MORGAN	431	12 JUN 03	1	OF 1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER Date Reported: 06-12-03

Officer Reporting: ANNALIESE WIERENGA ID#: 252 Date: 06-18-03
Officer Reviewing: [signature] ID#: 118 Date: 7-2-03
Offense(s): DEATH INVESTIGATION

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 12 June 2003, I responded to the Leon County Detention Center in reference to a death investigation. Upon arrival, I was advised that Inmate Clyde Fuller died while confined in the medical unit. The circumstances surrounding his death are as follows:
Inmate Fuller was transported to the Leon County Detention Center at 0150 hours by the Tallahassee Police Department. TPD Officer Damm #794 charged Fuller with trespassing and resisting without violence.

Intake officer Donald Hudson #345 completed an initial medical screening questionnaire which was signed by Fuller. Fuller answered "yes" to the following questions:
1.} Are you currently being treated for any medical problems.
6.} Seizures
9.} Are you addicted to drugs/ alcohol {Fuller circled "alcohol"}
10.} Are you currently under the influence
11.} Have you ever had D.T.'s or seizures after you quit drinking or using drugs

Fuller was then required to shower and provided with a detention center uniform.

***** The following information was obtained from the Prison Health Services paperwork and Nurse Linton's progress notes**

At 0345 hours, Nurse Debra Linton attempted to complete a medical screening on inmate Fuller with negative results. Nurse Linton stated that Fuller refused to cooperate with the screening process, or sign any of the required paperwork. Her report indicated that at one point he was speaking clearly but as the interview progressed he became increasingly agitated. She also described his behavior as "bizzare."
Nurse Linton stated that Fuller advised her that he had a history of seizures and that he had not taken his prescribed medication since 06-08-03.
Fuller further stated that he had prescriptions for the following medications: Dilantin, Depakote, Phenobarbitol.
Fuller also told nurse Linton that he had not consumed any drugs or alcohol prior to his arrest. Given his medical history, and the fact that she was unable to complete the screening, Nurse Linton requested that he be sent to the medical unit for further evaluation.

Per Sgt. Fryar's incident report, at 0355 hours, he and Officer Craig Carroll escorted Fuller to the medical unit.
According to Sgt. Fryar, Fuller was "talking to himself." Nurse McCabe attempted to complete the screening process however, Fuller refused to answer any questions. At that point, Nurse McCabe requested that inmate Fuller be placed in a paper gown and housed in the direct observation unit. Sgt. Fryar and Officer Carroll attempted to escort Fuller to room # 515. Fuller refused to walk and made several evasive movements. He then sat down on the floor refusing to move.

Officer James Morgan observed the altercation and rushed over to offer assistance. Fuller was cursing and screaming and spitting at the officers. He also started pushing and kicking violently. Fuller was then wrestled to the floor. Sgt. Fryar stated that Fuller continued to actively resist their efforts to control him and that he was put face down on the floor.
Officer Morgan sprayed Fuller in the facial area with OC pepper spray. At approximately 0400 hours, Sgt. Fryar ordered that the incident be videotaped. Officer Georgia Worener responded to the unit and videotaped the incident. Fuller was than placed in handcuffs and leg shackles. A towel was placed over Fuller's face to prevent him from spitting on the officers. According to Sgt. Fryar, the decision was made to place Fuller in the restraint chair. Officer's Fryar, Carroll, Bryant, Brown and Johnson placed Fuller in the restraint chair. After he was secured in the chair, Nurse McCabe administered a one milligram injection of Ativan. Nurse McCabe indicated on tape that the straps were satisfactory.

At 0412 hours, Inmate Fuller was wheeled into direct observation room # 515. The chair was positioned facing away from the glass window towards the wall. Officer Summerlin was assigned to the direct observation unit and was responsible for monitoring the inmates. According to the log book, Nurse McCabe returned to the unit at 0428 hours to check on Inmate Fuller. She observed that his head was slumped back on the chair, and noted that he was unresponsive to verbal stimuli. Nurse McCabe called for assistance and entered the room. She noted that Fuller's breathing was quite shallow and that his pulse was approximately thirty beats per minute. CPR was initiated by Officer Woerner and Nurse McCabe requested that Emergency Medical Services be notified. Fuller was removed from the restraint chair and placed on a bed. Nurse McCabe started an IV and hooked him up to the Auto External Difibulator device. At 0430 hours, Dr. Primas of the Prison Health Services was notified by phone of the incident.

At 0437 hours, EMS /Paramedic's Scott Hill and George Azar arrived on scene. Nurse McCabe informed them that the AED device she was utilizing was advising that the patient was in full arrest and needed to be shocked. According to Nurse McCabe the paramedics opted to utilize their own AED Device. Fuller did not respond to CPR or the AED Treatments administered by the paramedics. At 0505 hours, the ER Physician was called and Fuller was pronounced dead.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER Date Reported: 06-12-03

I responded to room #515. I observed Inmate Fuller lying on his back on the bed. He was dressed in a detention center uniform. The breathing apparatus utilized to revive him was still attached to his face and the AED stickers were attached to his chest. I observed debris from the medical procedures scattered on the floor. Fuller sustained a small laceration / abrasion on his right wrist as well as a slight abrasion to his left wrist. I also observed an abrasion on his right big toe and the top of his right foot. There were no other signs of trauma to the body.
Sgt. Fryar provided me with two videotapes. He stated that one of the tapes depicted the *use of force* utilized to control inmate Fuller and the other tape depicted the *medical procedures* utilized to revive him.

Detective Steve Woodcock of the LCSO Crime Scene Unit responded to the detention center. He videotaped and photographed the scene. I turned the aforementioned tapes over to him to be placed in evidence. Strong and Jones Funeral Home transported the body to the morgue.

Detective Jim Tyson and I conducted taped interviews with the following individuals: The correctional officers also submitted supplemental written reports.

Sgt. Terry Fryar
Officer Craig Carroll
Officer James Morgan
Officer Chris Bryant
Officer David Brown
Officer Georgia Woerner
Officer Charles Johnson
Nurse Debra Linton
Nurse Catherine Bratcher
Nurse Cathy McCabe

Interview Summaries:

Sgt. Terry Fryar's statements concurred with his written report. He added that Fuller became increasingly agitated when he learned that he was going to be housed in the medical unit. Fuller was very vocal and adamant about the fact that he did not want to stay in the medical unit and that he did not want to be placed in the "restraint chair." According to Sgt. Fryar, there was no mention of the chair prior to Fuller's arrival in the medical unit.

Officer's Carroll, Morgan ,Bryant, Brown, Woerner and Johnson's statements concurred with their written reports.

Officer Bryant added that he was assigned to the booking unit as an intake officer. He stated that upon Fuller's arrival, he conducted a search of Fuller and also printed him. He stated that Fuller had a strong smell of alcohol beverage on his person. Fuller also smelled like he had been smoking some type of substance. Bryant stated that he asked Fuller what he had been smoking and Fuller replied "cigarettes."

Nurse Catherine Bratcher stated that she responded to room #515 in reference to an inmate in distress. She stated that upon arrival, Officer Woerner was performing CPR on inmate Fuller. Nurse Bratcher stated that she assisted with ventilation efforts.

Nurse Debra Linton stated that she attempted to complete a medical screening on Inmate Clyde Fuller. She stated that he was cooperative at first and advised her that he suffered from seizures. He also stated that he had not taken any seizure medication since 06-08-03. She stated that he became increasingly agitated and refused to answer any more questions or complete the necessary paperwork. She stated that given his demeanor and medical condition, she felt like he needed to be evaluated in the medical unit. She stated that she contacted Nurse Bratcher by phone and advised her that Fuller was being transferred to medical for further evaluation.

Nurse Cathy McCabe provided the following information. She stated that she was assigned to the medical unit as the "charge nurse." She stated that Nurse Bratcher advised her that Inmate Fuller was being escorted to the unit for further evaluation. She stated that she met with Inmate Fuller and two correctional officers outside the nurse's station. She stated that Fuller was seated on a bench. Nurse McCabe stated that she asked him if he had any drugs in his system. She stated that Fuller would not answer any questions. She stated that he then began yelling at the officers stating "I'm not going to stay in the medical unit and I'm not going to be put in that chair." Nurse McCabe stated that there had been no mention of the restraint chair. She stated that given his current behavior and the fact that he had a history of seizures, she advised the officer that Fuller should be housed in the direct observation unit. She stated that at that point, Fuller went "ballistic." She stated that he began violently struggling with the officers and knocked over a nearby food cart. She stated that it took three officers to subdue him. She stated that Fuller was eventually put face down on the floor. She stated that he continued to resist the officer's efforts to control him. She stated that there was some discussion about putting him in the restraint chair. She stated that additional officers responded to the unit and that Fuller was placed in the restraint chair. She stated that after checking the restraints, she gave Fuller a one milligram injection of Ativan. She stated that he was then taken to room #515 in the direct observation unit.
Nurse McCabe stated that she returned to the unit a short while later. She stated that she observed that Fuller's head was slumped back in the chair and that he seemed unresponsive. She stated that she had Officer Summerlin unlock the door
in order for her to check on his condition. She stated that he did not appear to be breathing and that his heart rate was approximately thirty beats per minute. She stated that she immediately called for assistance. She stated that several officers arrived and CPR was initiated. She stated that Fuller was removed from the chair and placed on the bed.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER Date Reported: 06-12-03

She stated that she began an IV and also hooked him up to the AED machine. She stated that the machine indicated that he was in full arrest and needed to be shocked. She stated that at that point, the paramedics arrived. She stated that they essentially took over the revival efforts. She stated that they elected to utilize their own AED machine.
She stated that Fuller was unresponsive. She stated that approximately thirty minutes later, the paramedics consulted with a Tallahassee Memorial Hospital ER doctor. At 0505 hours, Fuller was pronounced dead.

At 1000 Detective Tyson and I responded to the morgue. Dr. Steve Sarbeck performed the autopsy. Dr. Sarbeck stated that his findings were inconclusive pending a toxicology report.

Detectives David Graham, and Mike Halligan responded to 1809 Saxon Street to make a death notification. They spoke with Mr. Fuller's grandmother, Evelyn Brown and his girlfriend Daquardra Kelly. Ms. Kelly stated that she would notify Mr. Fuller's father, Clyde Fuller Sr. Ms. Kathy Connolly of the Victim's Advocate Unit also responded and provided grief counseling to the family members.

Ms. Connolly later advised that Ms. Kelly stated that Mr. Fuller had been diagnosed as an epileptic. She stated that he had not been taking his prescribed seizure medicine. She further advised that he had a seizure approximately two weeks ago. Family members were unable to provide the name of Mr. Fuller's personal physician.

On 06-24-03, I met with Dr. Sarbeck and Dr. Stewart of the Medical Examiner's Office. They requested to review a copy of the videotape depicting the use of force methods utilized to control Inmate Fuller. Dr. Stewart stated that in his opinion there was no excessive force used to restrain Fuller.

On 06-25-03, I spoke with Dr. Sarbeck. He stated that he received a preliminary toxicology report. The report indicated that Fuller had marijuana and a significant amount of cocaine in his blood system. Dr. Sarbeck stated that Fuller may fit the profile of "sudden custody death syndrome." Dr. Sarbeck stated that he would provide me with a detailed report of his findings at a later date.

DISPOSITION RECOMMENDED
Pending

FLORIDA OFFENSE / INCIDENT REPORT - SUPPLEMENTAL / CONTINUATION 1. Original

Agency ORI Number	Agency Name	Agency Report Number	2. Supplemental 2
FLO370000	LEON CO. S.O.	03-98930	

Juvenile ____

Victim Name(s)	Original Date Reported (MDY)
Clyde Fuller	12 June 03

ADDITIONAL INFORMATION

On 12 June 03 at approximately 0619 hours I responded to 535 Appleyard Dr., the Leon County Jail, in reference to a death investigation. Upon arrival at approximately 0636 hours contact was made with Sgt. Curtis Parker who advised that the victim, an inmate identified as Mr. Clyde Fuller, B/M, DOB- 02-15-1977, was incarcerated last night and during the booking process Mr. Fuller had to be sprayed with pepper spray and restrained in a restraint chair. He was then taken to the medical ward and placed in a medical cell in the chair under observation. A short time later he was discovered to be unresponsive in the chair. He was removed from the chair by medical and jail staff personnel and CPR was performed without success.
The scene was videotaped, photographed and evidence collected.

SCENE

The scene was 535 Appleyard Dr., The Leon County jail medical ward room 1-515. Upon entering this room a bed is to the left and a small block partition that comes out from the wall on the right. Behind this partition is a toilet/ sink combination. There was misc. medical debris on the floor and bed area. A grey mattress was on the bed. The victim was located on his back on the bed. His head was face up with his arms down by his side. His feet were hanging over the end of the bed. The victims shirt was open exposing his chest. He also was wearing long blue jail pants and white underwear. The victim had white medical patches on his chest and back with smaller medical patches on his left and right shoulders. I observed an IV attached to his left arm at the inside of the elbow. A tube was attached with the end attached to an IV bag. A tube was inserted into his mouth with a strap around his head to hold it in place. I observed two small scratches on his right outer wrist and one on his left wrist. He also had an abrasion on his right big toe. I observed no obvious trauma to the body. Rigor Mortis was present throughout the body.

The chair which the victim had been placed in was in a hallway just outside this room.
I also obtained two video tapes from Det. Wierenga which were videos from the use of force and the medical help provided to the victim. Strong and Jones funeral home then responded to the scene and transported the victim to Tallahassee Memorial Hospital morgue.

On 12 June 03 at approximately 1000 hours I attended the autopsy of the victim which was performed by Dr. Sarbeck. I photographed the procedure and collected the victims clothing.

Evidence

Exh#1- VHSc video (use of force)
Exh#2- VHSc video tape (medical treatment)
Exh#S1- VHS video of scene
Exh#S2- clothing from victim
Exh#S3- armband of victim

DISPOSITION RECOMMENDED

Pending

Officer Reporting	ID Number	Date	Page
Detective Steven F. Woodcock	245	13 June03	1 of 1

Original Offense: Death Investigation

Reclassify To:

Continuation Contains
__ 1. Victim Statements __ 3. Evidence __ 5. Investigative Leads
__ 2. Witness Statements __ 4. Confession of Defendant __ 6. Other

Case Status	UCR Clearance Status		Date Cleared (MDY)	OBTS Number
1. Closed	1. Arrest/Adult	4. Exceptional/Juvenile		
2. Pending	2. Arrest/Juvenile	5. Unfounded	Related Report Number	
3. Other	3. Exceptional/Adult			

Officer Reviewing (if applicable) Sgt Lora Cormier Date 06-13-03

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: 2 Juvenile:

Agency Report Number: **03-098923** Victim Name(s): **Fuller, Clyde** Date Reported: **06-12-03**

Officer Reporting: **Detective Michael Halligan** ID#: **254** Date: **06-14-03**
Officer Reviewing: [signature] ID#: 118 Date: 7-2-03
Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Thursday 06-12-03, Detective David Graham, Kathy Connolly (Victim's Advocate), and this detective responded to 1809 Saxon Street to make a death notification. Detective Graham and myself spoke with Evelyn Brown (grandmother) and Daquardra Kelly (girlfriend, and mother of his child). I advised both of them that Clyde Fuller had passed away at the Leon County Jail earlier that morning. Daquardra Kelly advised that she would tell Clyde Fuller's father. Kathy Connolly provided comfort and relief to both Daquardra Kelly and Evelyn Brown.

DISPOSITION RECOMMENDED

PENDING

LEON COUNTY SHERIFF'S OFFICE

ADMINISTRATIVE INVESTIGATIVE REPORTING FORM

AIB CASE NO: A03-21

DATE RECEIVED COMPLAINT: 12 June 2003

DATE REPORT COMPLETED: 9 July 2003

COMPLAINANT: Major Carl Bennett
Leon County Jail
922-3500

MEMBER INVOLVED: Not Applicable

INVESTIGATOR: Sgt. Tim Baxter
Administrative Investigations Bureau

KWB 7-9-03

DISCIPLINARY STANDARD
Not applicable.

Jail Death/Administrative Review

SYNOPSIS OF COMPLAINT
On 16 June 2003, Inmate Clyde Fuller SPN 109820 was discovered deceased in a medical infirmary cell. He died while restrained in a restraint chair.

INVESTIGATIVE NARRATIVE

On 12 June 2003 at 0150 hours Clyde Fuller was brought to the Leon County Jail by the Tallahassee Police Department. He was booked in for Trespassing and Resisting An Officer Without Violence. He was processed at 0336 hours. During the processing Nurse Debra Linton was unable to do a thorough medical screening due to his abhorrent behavior. He was talking to himself, and otherwise not giving needed information. Based on this Nurse Cathy McCabe made the decision for him to be taken to medical to be better evaluated. She wanted him placed in direct observation in a paper gown. At approximately 0355 hours he was escorted to the medical unit by Sgt. Terry Fryar and Officer Craig Carroll. Once in the medical receiving area he began to resist, first by squatting on the floor and refusing to move, then escalating to active physical resistance. His resistance included the flailing of his arms and legs as well as spitting at the officers. At one point pepper spray was utilized but it had little affect. Once he was restrained with handcuffs and leg irons Nurse McCabe authorized his being placed in a restraint chair due to his continued aggressive mannerisms. Due to his continued attempts to spit on the officers Sgt. Fryar ordered a towel be draped over his face. Once he was secured in the restraint chair Nurse McCabe administered an injection of Ativan to him. At this point he appeared to calm down. He was then placed in a direct observation cell. The time was approximately 0412 hours. At approximately 0428 hours Nurse Braethcher went in the cell to check on Inmate Fuller. She discovered he was in medical distress and assistance was summoned. CPR and other lifesaving measures were initiated to no avail. The room was then secured and the proper persons notified to begin the necessary investigations.

The death investigation was conducted by Detective Analiese Wierenga of the Crimes Against Persons Unit. A copy of her report is included in this case file. Several references will be made to her investigation in this report. The death investigation revealed no foul play was involved in the death. An autopsy on Inmate Fuller revealed no readily apparent visual cause of death. Toxicology results are forthcoming. A video tape of the struggle with Inmate Fuller and the placing of him into the restraint chair was seized by Detective Wierenga in her investigation. It shows the level of resistance being displayed by Inmate Fuller as well as the officer's response to it. It reveals no improper actions on the part of the involved employees. The tape is started at the point Inmate Fuller is being restrained on the floor and terminates with his being placed into a medical unit cell in the restraint chair. There is a second tape that show the lifesaving measures attempted by correctional and medical staff. These video tapes are stored under case number 03-98930 in this agencies evidence section,

Following is information obtained in interviews of the involved correctional and medical staff by myself and Detective Wierenga.

Sgt. Terry Fryar

He was the on duty shift sergeant at the time of this incident. At approximately 0150 hours Inmate Fuller was brought into the jail by TPD. Around 0355 hours he was escorted to medical due to abhorrent behavior while Nurse Linton was attempting to interview him. The inmate did tell her he had "seizures." Officer Carroll and himself walked the inmate to medical. The inmate

was mumbling and nonsensical. Nurse McCabe ordered for him to be put in a paper gown and placed in direct observation. They told him to stand up (he was seated on a bench), so they could walk into the back. He started saying, "I don't wanna go in the chair, I don't wanna go in the chair." He then squatted on the floor and began to physically resist the officer's efforts to control him. Officer Morgan sprayed him in the facial area in an attempt to make him comply. At that point they were able to get his hands secured with handcuff. Nurse McCabe then said to place him in the restraint chair. They then got him off the floor and placed him in the restraint chair. He estimates they got him in the chair at about 0405 hours. Nurse McCabe gave him an injection to calm him. He almost immediately calmed down. During the struggle a towel was draped over the inmates face due to him spitting at the officers. When they placed him in the room the towel was removed from his face. Sgt. Fryar also returned back to the medical unit to assist in the lifesaving measures. **End of statement.**

Officer James Morgan

He was the assigned medical officer on the night/morning of this incident. He had just finished serving feed up in the infirmary when he heard a commotion in the medical unit receiving area. He observed Sgt. Fryar and Officer Carroll escorting Inmate Fuller to one of the direct observation rooms. He was being resistant and was cursing loudly. At one point he squatted on the floor and refused to move any further. They tried to get him up and he began to increase his physical resistance. He also was attempting to spit on the officers. At this point Officer Morgan went over to assist. Inmate Fuller began to flail his arms and legs around attempting to strike the officers. The officers were having a hard time controlling him. They finally took him to the floor where he continued to struggle. Officer Morgan then deployed OC spray to his facial area. The spray seemed to have no affect. Constant verbal commands were being given by the officers. They were able to get him handcuffed and shackled. Then Officer Morgan assisted getting him into the restraint chair. A towel was draped over Inmate Fuller's face to prevent him from spitting on the officers during this struggle. Officer Morgan ended his assistance once Fuller was restrained in the chair. He did not notice at any time during the struggle that Inmate Fuller was in any type medical distress. **End of statement.**

Officer Chris Bryant

He was the assigned as the male booking officer on the night of this incident. His initial contact with Inmate Fuller consisted of normal intake procedures, pat down, fingerprinting, etc... He did note that Fuller appeared "agitated," and smelled of alcoholic beverages. He later responded to the altercation in medical. When he arrived Inmate Fuller was on the floor in handcuffs with Sgt. Fryar, Officer Carroll, and Officer Morgan attempting to control him. He was cursing, yelling and attempting to "wiggle" away. Inmate Fuller then began to try and spit on the officers so Sgt. Fryar told Officer Bryant to get a towel and hold it over Fuller's face. They then got him into the restraint chair. Inmate Fuller continued to resist the officer's attempts. Nurse McCabe gave the inmate a shot in his left arm. After the injection was given they wheeled him into room 515. His behaviors had calmed considerably at this time. Officer Bryant then returned to his post in booking. He was then called back to medical when the inmate was discovered to be in medical distress. **End of statement.**

Officer Georgia Woerner

Officer Woerner was assigned to female booking on the night of this incident. Her initial contact with inmate Fuller involved the video taping of the struggle in medical. She then later responded to the medical distress call, the nurses in the room stated he was "dying." so she began chest compressions on inmate Fuller. She did continual chest compressions until inmate Fuller was pronounced by the emergency room doctor. **End of statement.**

Officer Craig Carroll

Officer Carroll was assigned as the property officer on the night of this incident. At approximately 0345 hours he took inmate Fuller from booking to the shower. The inmate was verbally rambling but was not uncooperative or aggressive. He was dressed in blues and taken back to booking to be medically screened by Nurse Linton. He was uncooperative so she was unable to screen him. Officer Carroll then escorted the inmate to medical and was assisted by Sgt. Fryar. He was seated on a bench to be interviewed further by medical staff. Nurse McCabe attempted to get more information but was unsuccessful. She then ordered him to be placed in direct observation in a paper gown. They attempted to escort him the medial infirmary. Inmate Fuller sat down on the floor. As they attempted to get him up he began to kick at them and swing his arms. They placed him face down on the floor and he continued to struggle. Officer Morgan sprayed him with OC foam. He still did not comply. They were able to get handcuffs on inmate Fuller. With the assistance of other officers they placed him in a restraint chair. A towel was held over his face due to his attempting to spit on the officers. They then placed him in a direct observation cell. He responded to the medical distress call and assisted in getting Fuller out of the restraint chair. He assisted at one point with the ambulatory bag. **End of statement.**

Nurse Debra Linton

Nurse Linton is a registered medical assistant. She is an employee of Prison Health Services. On the night of this incident she was assigned as the medical staff worker in booking. She attempted to do a medical screening of inmate Fuller. She was unable to complete it because he was uncooperative. He did tell her he had a history of seizures, was on medication for them, and had not been taking them. She did not notice any indications he had been consuming alcohol or drugs. He also denied having consumed any. As time went on he became more and more agitated. She called medical to inform them she was sending inmate Fuller down for further evaluation. **End of statement.**

Nurse Cathy McCabe

Nurse McCabe was the charge nurse on the night of this incident. She is an employee of Prison Health Services. She is a Registered Nurse. She recalls Inmate Fuller being brought into medical about 0400 hours. Nurse Debra Linton had briefed her on Inmate Fuller's demeanor. She was told he was cooperative at first in booking but then refused to sign anything or give more information. He had told Nurse Linton he was on seizure medication and had not had it since Sunday 8 June 2003. As he continued to stay longer in booking he got more and more agitated. When Nurse McCabe first observed him he was sitting on a bench in medical. He was very agitated. She asked him if he had used any drugs or anything else. He would not answer

her. He was yelling at the officers saying he was not going to stay in medical and he would not be put in the "chair." His agitation increased markedly at this time. They then went to escort him to an observation room. The inmate then went "ballistic." He began to physically resist very aggressively. He "jumped" on the officers. He attempted to kick, hit, and spit on them. He was almost "crazy." The officers got him to the floor on his stomach. During the struggle he was pepper sprayed. A food cart was knocked over. Nurse McCabe was "surprised" at the strength the inmate was displaying considering his small stature. The three officers were having a difficult time physically controlling him. They were finally able to get handcuffs and shackles on him. The chair was called for. She is not sure who initiated the request for the chair. He was placed in the chair and she checked his restraints. He had no obvious signs of injury. She did give him a one milligram injection of Ativan to calm/relax him. She stated once he was placed in the chair he had already began to calm down. She did not believe the injection had any immediate affect on him. He was then placed in the observation room. She did a check on him a short time later. She observed his head slumped back in the chair. She had Officer Summerlin let her into the room. The inmate was unresponsive. He did not appear to be breathing and his heart rate was around 30 beats a minute. She told the officer to call EMS. She and responding personnel initiated CPR on him. They also removed him from the chair to better facilitate this. She started an I.V. and gave him an injection of epinephrin. EMS responded and took over the lifesaving measures to no avail. **End of statement.**

Nurse Catherine Braetcher

Nurse Braetcher is a registered nursing assistant. She is an employee of Prison Health Services. She received a call from nurse Linton about inmate Fuller becoming agitated in the booking area. She told nurse Linton to go ahead and bring him down to the medical unit. She did not observe any of the struggle. She did go down to the cell once the inmate was in medical distress. She used the ambulatory bag to provide breathing assistance to the inmate. She started this while he was still in the restraint chair. **End of statement.**

Officer Charles Johnson

Officer Johnson arrived at medical once they were getting ready to be place Inmate Fuller in the restraint chair. He assisted in securing the inmate into the chair. He recalls the inmate continually struggling even while being secured in the restraint chair. A towel was draped over the inmates face due to his continued efforts to spit on the officers. Once the nurse gave the injection to the inmate he seemed to immediately calm down. Officer Johnson did not observe the inmate in any type medical distress during the struggle. **End of statement.**

Officer David Brown

Officer Brown was the assigned internal escort officer on the night of this incident. He responded to the medical unit in response to the call for assistance. Several officers were on the floor struggling with Inmate Fuller at the point he arrived. Inmate Fuller's hands were cuffed. Officer Brown went to the front desk and retrieved shackles for him. He observed a towel draped over the inmates face. As they were placing the inmate in the chair he held the towel on the inmates face. While in the chair the inmate was given an injection by one of the nurses. The inmate was then placed into an observation room. At that point Officer Brown removed the towel from over the inmates face. He then returned to his assigned area. He came back to

medical when the call for an inmate in distress went out. He filmed the lifesaving measures. **End of statement.**

Officer William Summerlin

Officer Summerlin was the assigned Direct Observation Officer on the night of this incident. He overheard the struggle in the medical receiving area. The inmate (Fuller) was hollering and screaming. The officers kept attempting to get him to calm down. One of the officers came and got the restraint chair. They then rolled the chair into the room with the inmate in it. The inmate's head was slumped back in the chair and he had a "pillowcase" draped over his face. Once they had him in the room the "pillowcase" was removed. A short time later Nurse McCabe came in to check on him and discovered him unresponsive. Lifesaving measures were immediately initiated. **End of statement.**

On 24 June 2003 Detective Wierenga met with Doctors Sarbeck and Stewart of the Medical Examiner's Office. They viewed the video tape of the use of force on Inmate Fuller. They determined that in their opinion no excessive force was used.

On 26 June 2003 Dr. Sarbeck advised Detective Wierenga that a preliminary toxicology report indicated Inmate Fuller had marijuana and a "significant" amount of cocaine in his system. He also stated Inmate Fuller may fit the profile of a "sudden custody death syndrome." The autopsy report and completed toxicology report is forthcoming.

FINDINGS

My investigation of this incident reveals no General Orders were violated.

ATTACHMENTS

1) Use of Force Reports by all involved officers, attached to this report.
2) Offense Report #03-98930, attached to this report.
3) Video tapes of the use of force and lifesaving measures, stored in evidence.
4) Cassette taped interviews of: Sgt. Terry Fryar; Craig Carroll, James Morgan, David Brown, Chris Bryant, William Summerlin, Charles Johnson, Georgia Woerner, Cathy McCabe, Debra Linton, and Catherine Braetcher; copies attached to this file.
5) Direct Observation Log

LEON COUNTY SHERIFF'S OFFICE
OFFENSE/INCIDENT REPORT

Attachment # 4
Page 44 of 87

AGENCY ORI #370000

Juvenile	N
Original 1 / Supplement 2	1
Incident Report #	030821193
Reported Day	FRIDAY
Date	5/16/03
Time	0440
Dispatched	0440
Arrived	0440
Completed	0505
Occurred Date	5/16/03
Time	0440
To Date	5/16/03
Off # 1 Offense	DEATH INVESTIGATION
Statute	99999
Incident Location	535 APPLEYARD DRIVE
Zip	32304
Geo	8-16
TL/LC	TL
Area Identifier	LEON COUNTY JAIL
F.E.	0
Occ.	1
Location	19
Weap. Type	00
# Offenses	00
# Victims	01
# Offenders	00
# Prem. Ent.	00
# Veh. Stolen	00

Person

Off #	001
VWS #	V1
Type	3
Name (Last, First, Middle)	HUBBS, RUTH
Address	1601 PEPPER DR. TALLAHASSEE FLORIDA 32304
Race	W
Sex	F
DOB	9/10/62
R.T.	2
R.S.	0
EOI	4
Inj. Type	010
Relation	00
Height	510
Weight	240
Eye Color	HAZ
Hair Color	BLN

Officer Reporting: MASON L BATON 346 CORRECTIONS 16 MAY 03
Officer Reviewing: SGT CUMMINGS, ID Number 105

Page 1 OF 4

FMI #23100 4/98

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2		REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193

ON 16 MAY 03 AT APPROXIMATELY 0440 HOURS I WAS IN THE PROCESS OF PASSING BREAKFAST FEED UP IN THE MEDICAL UNIT OF THE LEON COUNTY DETENTION FACILITY. NURSE LURLINE BROWN RN WAS ESCORTING ME AS I PASSED BREAKFAST TRAYS TO THE FEMALES HOUSED IN THE MEDICAL UNIT. I UNLOCKED THE DOOR TO ROOM 520-B TO ISSUE A TRAY TO INMATE HUBBS, RUTH M. SPN# 148608. AS I OPENED THE DOOR NURSE BROWN WALKED IN THE ROOM TOWARD THE NORTH EAST CORNER OF THE ROOM WHERE INMATE HUBBS WAS LYING ON THE FLOOR ON HER RIGHT SIDE. I WAS HOLDING THE DOOR OPEN FOR THE NURSE, AND HOLDING THE BREAKFAST TRAY. AT THAT TIME NURSE BROWN DID NOT ACT LIKE THERE WAS ANY CAUSE FOR ALARM, AND SAID "SHE DOES THIS". THEN NURSE BROWN BEGAN TAPPING INMATE HUBBS AND REPEATING "WAKE UP". INMATE HUBBS DID NOT RESPOND. NURSE BROWN BEGAN CHECKING INMATE HUBBS FOR VITAL SIGNS AND THEN INFORMED ME THAT SHE NEEDED TO INITIATE C.P.R. AND TOLD ME TO CALL FOR ASSISTANCE TO MOVE INMATE HUBBS OUT OF THE CORNER OF THE ROOM, AND HAVE AN AMBULANCE ON THE WAY. I CALLED SGT. CHAMBERS ON THE RADIO AND ASKED HIM TO SEND ASSISANCE, AND CALLED CENTRAL CONTROL ON THE RADIO AND TOLD THEM TO HAVE AN AMBULANCE ON THE WAY. NURSE BROWN EXITED THE ROOM TO GET C.P.R. EQUIPMENT AND SEEK ASSISTANCE FROM NURSE ALICE GRANBERRY LPN. LT. BUSH CALLED ME ON THE RADIO AND ASKED ME IF I NEEDED THE AMBULANCE "10-18", WHICH MEANS LIGHTS AND SIRENS. I WALKED AROUND THE CORNER TO THE NURSE'S STATION AND ASKED NURSE BROWN TO CONFIRM WE NEEDED THE AMBULANCE WITH LIGHTS AND SIRENS, AND SHE SAID "YES". I CALLED LT. BUSH BACK AND CONFIRMED WE NEEDED THEM WITH LIGHTS AND SIRENS. I WALKED BACK TO ROOM 520-B. NURSE BROWN RETURNED WITH THE BAG CONTAINING C.P.R. EQUIPMENT. APROXIMATELY 1 MINUTE LATER, SGT. CHAMBERS ARRIVED AT ROOM 520-B. SGT. CHAMBERS NOTED THE LARGE SIZE OF THE INMATE AND CALLED ON THE RADIO TO ENSURE THAT OTHER OFFICERS WERE ON THE WAY, AS WE WOULD NEED HELP FOR LIFTING INMATE HUBBS OUT OF THE CORNER. I GRABBED HER ANKLES AND PULLED HER LEGS IN AN

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____ | Certifying Officer

___ Personally Known ___ Identified By ID #_____

OFFICER REPORTING	ID #	DATE	PAGE
MASON L. BATSON	346	16 MAY 03	2 OF 4
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE	
SGT CHAMBERS	103	16 MAY 03	

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2		REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193

ATTEMPT TO REPOSITION INMATE HUBBS' LOWER BODY. SGT. CHAMBERS ATTEMPTED TO REPOSITION HER UPPER TORSO DUE TO THE SIZE OF THE INMATE, AND AS SHE SEEMED "WEDGED" BETWEEN HER BUNK AND THE WALL, OUR EFFORTS WERE UNSUCCESSFUL. APPROXIMATELY 1 MINUTE LATER SEVERAL OFFICERS RESPONDED. SGT. RAGANS, OFC. JACOBS, JONAS, HAWKINS, BROOKS, LT. BUSH, AND OFC. KELLERMAN RESPONDED TO THE AREA. I STEPPED OUT OF THE ROOM TO GIVE THE LARGER AND MORE POWERFUL RESPONDING OFFICERS ROOM TO PERFORM. LT. BUSH, SGT. CHAMBERS, SGT. RAGANS, OFC. JACOBS, AND OFC. KELLERMAN SUCCESSFULLY LIFTED INMATE HUBBS FROM THE FLOOR ON TO THE BUNK IN ROOM 520-B. NURSE LURLINE BROWN RN, AND NURSE ALICE GRANBERRY LPN THEN BEGAN TO ADMINISTER C.P.R.. OFC. JACOBS WAS THE FIRST OFFICER THAT I REMEMBER SEEING USING A VIDEO CAMERA. HE COMPLAINED THAT HE DID NOT BELEAVE THE CAMERA WAS WORKING PROPERLY, AND IT DID NOT HAVE A TAPE IN IT. A TAPE WAS CALLED FOR, AND RECIEVED A SHORT TIME LATER. NURSE BROWN AND NURSE GRANBERRY CONTINUED C.P.R. UNTIL ED SKINNER, AND MARC DONOFRO OF EMS ARRIVED AT APPROXIMATELY 0500 HOURS. ED SKINNER, AND MARC DONOFRO PRONOUNCED INMATE HUBBS DEAD, ACCORDING TO THIER EVALUATION, AT APPROXIMATELY 0505 HOURS. I WAS TOLD BY SGT. CHAMBERS TO START A CRIME SCENE LOG. I STARTED THE CRIME SCENE LOG. IT WAS CONTINUED BY OFC. J. COBB AFTER I LEFT THE AREA.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
MASON L. BATSON	346	16 MAY 03	3 OF 4
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE	
SGT CHAMBERS Robert D. Chambers	103	16 MAY 03	

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	5/16/03	INCIDENT REPORT #	03082193

WITNESS: OFFICER M. BATSON #346
SGT. R. CHAMBERS #103
SGT. R. RAGANS #121
DEPUTY P. HAWKINS #360
OFFICER V. DAVIS #406
OFFICER J. KELLERMAN #361
OFFICER C. JACOBS #502
LT. T. BUSH #64

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID #_____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
MASON L. BATSON	346	16 MAY 03	4 OF 4
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE	
SGT CHAMBERS Robert O. Chambers	103	16 MAY 03	

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	5/15/03	INCIDENT REPORT #	0 3 0 8 2 1 9 3

On Thursday, May 15, 2003 at approximately 1900 Hours, I relieved Officer Hawkins at the medical front desk. I was briefed by Officer Hawkins and I made my first round at 1923 Hours. I observed Inmate Hubbs, Ruth spn #1486608 awake and sitting on the floor talking to herself. I asked her if she wanted to eat her Evening Meal and she told me No, that she had already eaten. At 2010 Hours I observed her still sitting on the floor talking to herself. At approximately 2030 Hours, I asked Inmate Hubbs if she wanted her food again and she told me No. I then moved her out of room #520C to room #520B and she sat down on her bunk and started talking to herself, she got up off of the bunk and used the restroom, then she sat back down on her bunk. I removed the telephone from room #520C to the Female holding cell #525 for other inmates to use. On my last observation of inmate Hubbs was at 2105 Hours. I then briefed the officer, Officer King and returned to my duties in Female Booking.

Affiant Signature
Velveeta D. Davies

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Velveeta Davies	406	15 May 03	1	OF 1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
SGT CHANDLER Richard O. Chandler	103	16 MAY 03		

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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05 16 03	INCIDENT REPORT #	0 3 0 8 2 1 9 3

ON 16 May 03 AT APPROXIMATELY 0445 HOURS I RESPONDED TO A CALL FOR ASSISTANCE IN MEDICAL. WHEN I ARRIVED AT ROOM #1-5208 I ASSISTED SGT CHAMBERS, LT BUSH AND D.P. JACOBS IN LIFTING INMATE RUTH HOBBS (148608) ON TO THE BED. I LIFTED THE INMATES LEFT ARM. ONCE THE INMATE WAS ON THE BUNK I LEFT THE ARM SO MEDICAL STAFF WOULD HAVE ROOM TO WORK.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE
John Kellerman	361	16 MAY 03
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE
SGT CHAMBERS	103	16 MAY 03

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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE		ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193

ON THE ABOVE DATE AT APPROXIMATELY 0455 HOURS, I RESPONDED TO AN EMERGENCY CALL FOR FEMALES OFFICERS TO ASSIST IN MEDICAL. UPON MY ARRIVAL, I SAW RESPONDING OFFICERS, LT. BUSH, SGTS' CHAMBERS, RAGANS, AND OFC'S' KELLERMAN, AND JACOBS PICKING INMATE HUBBS, RUTH SPN # 148608 OFF OF THE FLOOR AND PLACING HER ON THE BUNK. ATTENDING MEDICAL STAFF R.N. BROWN, LURLINE, AND L.P.N. CRANBERRY, ALICE BEGAN FIRST RESPONDER PROCEDURES. APPROXIMATELY 0500 HOURS EMERGENCY MEDICAL STAFF, SKINNER, EDDIE, AND DONOFRO, MARC RESPONDED AND ANNOUNCED THAT SUBJECT HUBBS, RUTH WAS DECEASED. DURING MY TOUR OF DUTY AS THE INFIRMARY OFC. FROM 1700 HOURS TIL 900 HOURS, HUBBS WAS ALIVE AND SPOKE WITH ME ON SEVERAL OCCASIONS.

Affiant Signature P/O Hawks P/O Hawkins # 360

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE 1 OF 1
OFFICER REVIEWING (IF APPLICABLE) SGT C. HAMBERS Robert D. Chambers	ID # 103	DATE 16 MAY 03	

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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03018211913

On 16 May 2003 at approximately 0445 hours I was directed by Sgt. Lee #106 to proceed to medical and see if they needed assistance. Upon arrival in medical I was directed to room 520B where I observed inmate Hubbs, Ruth Sp.# 148608 lying between the north wall and the bunk. I then assisted Lt. Bush #64 and Sgt. Chambers #103 in lifting inmate Hubbs on to her bunk, and then retrieved a camera from central. I recorded medical staff and E.M.S. as they attempted to revive inmate Hubbs, until told to stop recording by Sgt. Chambers #103 at 0505 hours.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	OF	PAGE
Chris Jacobs	502	16 May 03	1	OF	1
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SGT CHAMBERS	103	16 MAY 03			

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL – 1 SUPPLEMENT – 2	2	REPORTED DATE	5/16/03	INCIDENT REPORT #	03082193

ON 16 MAY 2003 AT APPROXIMATELY 0458 I RESPONDED TO MEDICAL DUE TO OFFICER M. BATSON #346 ASKING CENTRAL CONTROL TO CALL FOR AN AMBULANCE. I ARRIVED IN MEDICAL TO FIND INMATE RUTH HUBBS SPN # 148608 LAYING BETWEEN THE END OF THE BED AND THE WALL WITH HER FEET TOWARD THE TOILET. INMATE HUBB DID NOT APPEAR TO BE BREATHING. R.N. LOURLINE BROWN, LPN ALICE GRANBERRY AND OFFICER BATSON WERE PRESENT. INMATE HUBB WAS A VERY LARGE PERSON AND I CALLED FOR ADDITIONAL HELP TO LIFT HER ONTO THE BED. SGT. RAGAN, LT. BUSH, OFC. KELLERMAN AND OFFICER JACOBS ARRIVED IN LESS THAN A MINUTE AND ASSISTED ME IN LIFTING INMATE HUBBS ONTO THE BED. NURSE GRANBERRY AND NURSE BROWN BEGAN CAR. AT APPROXIMATELY 0453 THE AMBULANCE CREW ARRIVED. EMT EDDIE SKINNER AND EMT MARC DONOFRO TOOK OVER THE CARE OF INMATE HUBBS. AT 0505 THE EMT'S SAID THAT THEIR PROTOCAL WITH THEIR ASSESSMENT OF THE INMATE ALLOWED THEM TO PRONOUNCE INMATE HUBB DEAD. AT 0505 HOURS THE ROOM WAS SECURED WITH THE BODY INSIDE. OFFICER J. COBB WAS POSTED OUTSIDE THE DOOR AND CONTINUED KEEPING A RECORD OF WHO ENTERED THE ROOM. OFFICER BATSON STARTED THE LOG.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
SGT CHAMBERS #103 Richard D. Chambers	103	16 MAY 03	1 OF 1
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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	5/16/03	INCIDENT REPORT #	03082193

On 15 May 2003, at 0505, I put Inmate Ruth Hubbs' #148608 new Log Out. I Observed Inmate Hubbs sitting on the Floor yelling in Room 5206. At 0605 I Returned to Find Inmate Hubbs Standing at the Door. I Tried To Talk To Her, But She Didn't Make Any Sense. At 0640 I Escorted R.N. Curline Good-Brown on Rounds To Take Vitals. R.N. Good-Brown Took Inmate Hubbs' Vitals and Again I Tried To Talk To Her With no Success. Inmate Hubbs Had Poured Her Milk into Her Tray and was playing in it. I Removed the Tray from the Room. I Returned at 0740 and she was sitting on the Floor Talking to Herself. When I went back 0912 she was still sitting on the Floor Talking. At 1008 Inmate Hubbs had her Shirt off and had put it in the Toilet. I gave her a dry shirt and had her put it on. I Removed the wet shirt and a wet Blanket. At 1538 I gave her a Dinner Tray and Removed the Lunch Tray. She was sitting on the Floor so I set the Tray on the Bed. At 1600 she had Taken her Pants off, but had not Touched her Meal. I Returned with a pair of Pants at 1620 and Tried To get her Dressed. Her Toilet was not working and Maintenance was standing by to Fix it. At Approximately 1630 Sgt. Joyce McCary Came To Try and Help get her Dressed and Moved to Room 5203 We were Unable to get her off the Floor. I Requested the Help of R.N. Michael Morgan To Lift her. He Refused. Dr. Peinas and Natoshia Carr (Medical Mental Health Person), Came in To Evaluate Inmate Hubbs at Sgt. McCary's Request. Dr. Peinas was not Concerned with her Condition. He Told Sgt. McCary to just Let her lay There on the Floor. Both Sgt. McCary and I Exited the Room at 1650.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID#	DATE	PAGE
E. Dianne Brooks/E. Dianne Brooks	342	16 May 2003	01 OF 01
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Sgt. Joyce McCary	148	16 May 03	

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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193

On Thursday 15 May 2003, upon making initial contact with Inmate Ruth Hubbs, sp# 148608 at approximately 0821 hours, I observed her sitting on the floor talking to herself. At approximately 1112, I made another hourly check and found her still sitting on the floor talking to herself. I was unable to make sense out of what she was saying. At 1147, I made another hourly check on Inmate Hubbs and she was consistent with the same type of behavior that she had previously exhibited. At approximately 1222 hours, Inmate Hubbs was standing at the door talking, appearing very lethargic. I was still unable to make sense of what she was saying. At approximately 1310 hours, I entered the female infirmary along with Nurse Matilda Frazier and we found Inmate Hubbs on the floor and her legs were under the bed. She stated that she could not get up and her legs were stuck. She also advised us that she had fell. Nurse Frazier checked her head for bumps or bruises. Also her leg and arm were bruised. Nurse Frazier and myself assisted Inmate Hubbs so that she was able to sit up and eventually Nurse Frazier was able to give her the medication. After several attempts she was able to get the medication down. We then attempted to assist her in getting on the bunk and she was able to comply. At approximately

Affiant Signature

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Certifying Officer

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C.C. Buck Mayo	277	5-16-03	01 OF 02
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Sgt. Joyce McCary	148	5-16-03	

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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193

1438 hours, I made an hourly check on Inmate Hubbs and again found her sitting on the floor talking incoherently. Each time I entered the infirmary, I found Inmate Hubbs either sitting on the floor or standing at the door, each time appearing very lethargic and incoherent

Affiant Signature

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___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING Cpl. Linda D. Mize ID # 377 DATE 5-16-03 PAGE 01 OF 02

OFFICER REVIEWING (IF APPLICABLE) Sgt. Joyce McCoy ID # 148 DATE 5-16-03

FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082119 3

ON MAY 15, 2003 WHILE ASSIGNED TO MEDICAL SECURITY AS THE IMMEDIATE SUPERVISOR. I MADE NUMEROUS ROUNDS IN THE MEDICAL INFIRMARY. I DOCUMENTED (3) THREE OF THESE ROUNDS ON THE DAILY CONFINEMENT LOG OF INMATE RUTH HUBBS SPIN # 148608. AT 0828 HOURS I OBSERVED INMATE HUBBS SITTING ON THE FLOOR NEXT TO HER BUNK SHE APPEARED TO BE UNAWARE OF HER SURROUNDINGS. SHE WAS PULLING AT HER JAIL UNIFORM TOP AS IF SHE SAW SOMETHING ON IT, CONSTANTLY TALKING TO HERSELF. NURSE EMILIE BECK D.O.N. WAS PRESENT. SHE ADVISED ME SHE WAS WORKING ON GETTING MORE MEDICAL RECORD INFORMATION ON INMATE HUBBS, AND THAT SHE WAS GOING TO TALK WITH SUE COLE (PRISON HEALTH SERVICES) ADMINISTRATOR. AT 1130 HOURS I OBSERVED INMATE HUBBS SITTING ON HER BUNK TALKING TO HERSELF. AT 1158 HOURS I OBSERVED INMATE HUBBS STANDING NEAR HER BUNK ROLLING UP HER MATTRESS TALKING TO HER SELF. LATER THAT DATE I SPOKE WITH MRS. NAUTOSHIA CARR ABOUT HER BEHAVIOR. MRS. CARR WENT TO THE INFIRMARY AND OBSERVED INMATE RUTH HUBBS BEHAVIOR. MRS. CARR LATER ASKED ME IN A BRIEF CONFERENCE WITH MRS SUE COLE IN HER OFFICE. I SAT DOWN IN MS COLE'S OFFICE AND SHE ADVISED ME THAT SHE HAD ALREADY TALKED WITH MRS. HUBBS SATURDAY AND INMATE HUBBS RESPONDED TO HER QUESTIONS AND THEY HAD A NORMAL CONVERSATION. MRS. COLE ADVISED THE INMATE HUBBS DO HAVE SOME MENTAL ISSUES BUT HUBBS IS PUTTING ON HECK OF A SHOW. AND THAT HUBB LOVES ATTENTION, AND I LEFT THE OFFICE.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

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Sgt. Joyce McCary	148	16 May 03	01 OF 02
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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY/ORI # FLO 370000	JUVENILE	ORIGINAL - 1 / SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT #
		N / 2	05/16/03	03038119 3

I SPOKE WITH DR. PRIMAS AND ADVISED HIM OF THE BRUISES ON INMATE HUBBS LEFT ARM. HE ADVISED ME THAT HE WOULD CHECK IT OUT. MR. WAGE GIBSON CAME DOWN TO REPAIR HUBBS TOILET, DUE TO IT WOULD NOT FLUSH ANYMORE. HE HAD TO WAIT ABOUT (15) MINUTES FOR MYSELF AND OFFICER DIANE BROOKS TO GET HER TO PUT HER JAIL UNIFORM PANTS ON. INMATE HUBBS WAS STILL ON THE FLOOR, SHE GOT UP AND DOWN UNTIL SHE PUT HER PANTS ON. SHE WENT FROM SITTING ON THE FLOOR TO HER KNEES. ONCE SHE WAS DRESSED, I ASKED HER TO STAND UP UP SO WE COULD MOVE HER TO THE ROOM ACROSS FROM WHERE WERE SO MAINTENANCE COULD REPAIR HER TOILET. SHE STARED TO GET UP ON ONE KNEE AND SAT BACK DOWN. NURSE MICHAEL MORGAN CAME TO THE AREA JUST OUTSIDE THE ROOM OFFICER BROOKS ASKED HIM TO HELP GET HUBBS UP OFF THE FLOOR HE SAID NO, AND LEFT THE AREA. I HAD MR. GIBSON TO COME IN AND REPAIR THE TOILET HE HAD ALREADY BEEN WAITING ABOUT (15) MINUTES. INMATE HUBBS WAS LYING ON THE FLOOR IN THE MIDDLE WAYS OF THE ROOM. JUST LAYING ON HER BACK SHE SAID SHE WAS TIRED AND FAT. WHILE MR. GIBSON WAS STILL REPAIRING THE TOILET DR. WILLIAM R. PRIMAS CAME TO THE ROOM DOOR AND SPOKE WITH INMATE HUBBS. HE ASKED HER WHAT WAS WRONG WITH HER SHE SAID SHE WAS FAT. I SHOWED DR. PRIMAS HER LEFT ARM AND HE SAID NOTHING NEEDED TO BE DONE WITH IT. I ASKED DR. PRIMAS TO DOCUMENT THAT HE SAW HER. HE SAID OKAY AND LEFT THE AREA. INMATE HUBBS WAS STILL LAYING ON THE FLOOR TALKING ABOUT SHE IS FAT. MR. GIBSON REPAIRED THE TOILET AND WE EXITED THE AREA.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____ | Certifying Officer

___ Personally Known ___ Identified By ID # _____

OFFICER REPORTING	ID #	DATE	PAGE
Sgt. Joyce McCoy	148	16 May 03	PAGE 02 OF 02
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LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	5/16/03	INCIDENT REPORT #	03082193

ON the 16th of MAY 2003 AT Approximately 0440 hrs, I Responded to Medical, after hearing over the Radio, Assistance Needed in that Area. When I Arrived to Room 520 B, I observed a female Inmate, Hubbs, Ruth spn 148608 laying on the Floor At the front side of her Room. Sgt. Chamber and several Officers were present, Attempting to move this inmate from the floor to her bunk. Sergeant chambers Instructed me to go and make A copy of the Log, Which I did. At Approximately 0450 hrs, I paged Lt. Charles DAVIS to inform him of this incident. Lt. DAVIS Instructed me to contact Lt. Pete TAylor. At Approximately 0500 hrs. I contacted Lt. Leroy Johnson, and advised him of this incident. Lt. Bush was also at the Medical Front desk talking with Capt. Peterson, Advising her of this situation. I spoke with Capt. Mills At Approximately 0515 hrs, advising him of this incident. I left this Area At Approximately 0530 hrs, in Route to booking to Attend my Normal / assigned duties.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Sgt Ronnie Ragans 121 / Ronnie RAGANS 121		16 MAY 03	1 OF	1
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FMI (11/97)

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: 03-082193 Victim Name(s): **Hubbs, Ruth** Date Reported: 05/16/03

Officer Reporting: **Detective P. Iadanza** ID#: 337 Date: 05/21/03
Officer Reviewing: Sgt. Tona Carmichael ID#: 140 Date: 05-22-03
Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: 05/16/03 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On the above date, I was called out to process a death investigation scene at the Leon County Jail. Upon my arrival, I made contact with Detective J. Giordano (#224) and Sergeant C. Parker (#118), both of whom are with the Persons Unit.

I was advised, by Detective Giordano, that the inmate, Ruth Hubbs, had been found dead on the cell floor. According to the nurse, she had checked on Ms. Hubbs several times during the night and had noticed that she was sleeping on the floor. He also advised me that he had been informed, by the nurse, that Ms. Hubbs had a habit of sleeping on the floor so she did not think anything was out of the ordinary.

Sergeant Parker advised me that it was discovered that Ms. Hubbs was deceased when the Correctional Officer and the nurse brought in Ms. Hubbs' breakfast. He also advised that the nurses and several correctional officer had moved the victim from the floor to the bed.

I approached the cell, number 1-520 Patient B, and viewed the cell area through the glass opening in the door. I noticed a heavy set white female laying on her back, on the cell bed. She was covered with a sheet and there was an emergency medical bag on the bed, up near her head. I also noted that there were several stick on type patches, of the type similar for EKG leads, that were still attached to her body. On the victim's face some lividity had begun to set in, as well as on some of her extremities.

I proceeded to video the scene, as well as take 35mm and digital photographs, of the entire area. The video and photographs were placed into the evidence vault of the Leon County Sheriff.

I photographed the victim, where she was lying. At this time, the victim was not rolled over or the body examined any further, per Sergeant Parker.

On the same date, I attended an autopsy performed by Dr. Mahoney. Additional photographs were taken at the morgue.

On today's date, I returned to the scene to take measurements of the empty jail cell.

DISPOSITION RECOMMENDED: Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

Officer Reporting: **Detective James F. Giordano** ID#: **224** Date: **06-09-03**

Officer Reviewing: Sgt. C Parker ID#: 118 Date: 6-19-03

Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday the 16th of May 2003 I was contacted by Lt. Bush the watch commander at the Leon County jail indicating that there had been an in custody death at the Jail. Lt. Bush said that an inmate by the name of Ruth Hubbs had been discovered deceased in a medical holding cell at or around 0440 hrs. I made contact with Sgt. Curtis Parker and made him aware of the incident.

Upon arrival at the Leon County Jail (0602 Hrs.) I was directed to the medical unit (female side) and viewed a deceased white female laying on the metal bunk in room 520-B. The deceased subject was laying face up with her head toward the south and her feet toward the north. Crime scene Detective Patti Iadanza responded to the scene and took control of processing the scene.

At that time I conducted interviews with both correctional staff and the medical staff responsible for care of inmate Ruth Hubbs on the night of question concerning her death. Sgt. Curtis Parker was left in control of the crime scene at that time.

In a taped interview which started at 0653 hrs and ended at 0716 hrs Correctional Officer Batson indicated the following. While he was issuing food trays, he discovered Hubbs laying on the floor in her cell. Hubbs was laying at the foot of her bed between the wall and the bed posts. Accompanying Batson was the nurse on duty Lurline Brown. Lurline Brown indicated that Hubbs was not breathing and requested EMS be called. Additional correctional officers responded to the call for help. Hubbs was picked up off the floor and placed on her bunk. Life saving measures were started and EMS arrived.

At 0727 hrs I conducted a taped interview with Sgt. Robert Chambers which ended at 0731 hrs. He indicated that he responded to medical as the acting supervisor. He also assisted in lifting Hubbs off of the floor.

I spoke to Correctional Officer Christopher Jacobs and our interview was taped. The taping started at 0737 hrs. and ended at 0745 hrs. He indicated that he responded to the medical unit to assist in lifting Hubbs off of the floor. He then went and got a video camera and taped the rest of the immediate incident

A taped interview was conducted with Correctional Officer Hawkins. The taped interview started at 0747 hrs. and ended at 0800 hrs. She indicated that she spoke to Hubbs while she was alive the night of the incident. Hubbs was in room 520-C when spoken to and she had requested to use the telephone. Correctional Officer Hawkins said that when Hubbs died she was not in the same room as she saw her alive in. Correctional Officer Hawkins did not know why Hubbs had been moved or who moved her.

A taped interview which started at 0802 hrs and ended at 0812 hrs was conducted with Lt. Wilson. He said he was the watch commander the night of the incident. He said that he was leaving the Jail when he heard the call and came back to assist. He had no hands on involvement with Hubbs.

Correctional Officer Kellerman was interviewed about his involvement in the incident. The taped interview started at 0814 hrs and ended at 0846 hrs. Correctional Officer Kellerman responded to medical to assist in lifting Hubbs off of the floor. She was purple in the face and not breathing.

A taped interview was completed with nurse Lurline Brown and it ended at 0917 hrs. Brown said that she first had contact with Hubbs on Wednesday the 14th of May. Hubbs was in cell 520-C and she was laying on her bunk. Hubbs appeared to be sleeping but Brown said she saw very little respiration movement. Brown went into the cell and discovered that Hubbs was breathing and was snoring. Later in the morning Brown said that she viewed Hubbs laying on the floor and she was awake.

On Thursday the 15th of May Brown said that she saw Hubbs in 520-B and she was laying on the floor. Hubbs was at the foot of her bed between the bed and the wall. Several hours later Brown discovered Hubbs laying deceased on the floor. Hubbs was found when Nurse Brown went into the cell to check on her welfare. Brown went into the

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: 03-082193 Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

cell because Hubbs did not answer when she was called out to. When Brown discovered Hubbs was not breathing she started life saving measures. CPR was done until paramedics arrived and took over.

In a taped interview that started at 0924 hrs. and ended at 0937 hrs. Correctional Officer Velveeta Davies provided the following. Davies had interaction with Hubbs when she asked her to move from cell 520-C over to cell 520-B. When asked to move, Hubbs got up and walked across the hallway. Davies said she asked Hubbs to move because the main log in medical showed her in cell 520-B.

Inmate Hubbs was transported to Tallahassee Memorial Hospital by Clary's Funeral Home. The body was escorted by Detective Dawn Butler to the morgue. An autopsy was performed by Doctor Mahoney at 1100 hrs on 05-16-05. No trauma or injuries which would cause death were located. At the conclusion of that autopsy the medical examiner was not able to determine a cause of death. At this time Doctor Mahoney is awaiting the results from a toxicologist screening of inmate Hubbs blood to further his findings.

A taped interview was completed on Tuesday the 20th of May with Correctional Officer Tillman. The interview started at 1551 hrs and ended at 1604 hrs. Tillman said that on Sunday the 4th of May Hubbs went to sit down on a chair and fell to the floor. Hubbs missed the chair all together and fell straight down on her rear end. Tillman said that she sent Hubbs down to medical to have her checked out. Tillman said that she did not see any apparent injuries to Hubbs that she might have sustained in the fall.

A taped interview was conducted with Correctional Officer Finn on Wednesday the 21st of May. The interview started at 1653 hrs. and ended at 1735 hrs. Finn said that she had dealings with Hubbs while she was in pod-M. Her dealings were of a normal nature. Finn was on duty when Hubbs was moved to medical on Wednesday the 14th of May. Finn said that Lt Liz Black and Sgt Bill Parramore came into the unit on Wednesday the 14th of May and moved Hubbs down to medical.

In a taped interview with Sgt. Parramore (which started at 1732 hrs. and ended at 1744 hrs) he provided the following information about his involvement with inmate Hubbs. On Tuesday the 13th of May and Wednesday the 14th of May Parramore saw Hubbs while she was in her cell in pod-M. Parramore said that Hubbs was sitting on the floor and was speaking in slurred speach. Parramore said that Hubbs was unable to get up off of the floor. Parramore said that on Wednesday the 14th of May he assisted in moving Hubbs down to medical. The moving of Hubbs was based on the fact that Hubbs was not able to get up off of the floor. Parramore said this was the last time he had dealings with Hubbs.

A taped interview was done with Lt. Liz Black which started at 1805 hrs. and ended at 1843 hrs. The interview with Lt. Black provided the following information. Lt. Black also had dealings with Hubbs on Tuesday the 13th of May and Wednesday the 14th of May. Lt Black was the watch commander both of those days. Lt Black said that she assisted in moving Hubbs down to medical on Wednesday the 14th of May. Hubbs was moved due to her inability to get up off of the floor. It was also based on the fact that Hubbs was not able to carry on a normal conversation. When Hubbs was moved down to medical Lt Black said she was put in cell 520-C. This was the last interaction Lt. Black had with Hubbs.

On Tuesday the 27th of May I conducted a taped interview with Correctional Officer Clete King. The interview started at 1311 hrs. and ended at 1322 hrs. King could not provide any additional information pertinent to the death investigation.

On Tuesday the 27th of May I also taped an interview with Doctor Primas. The interview was started at 1210 hrs and concluded at 1304 hrs. Doctor Primas is the medical doctor responsible for the health care at the Leon County Jail. Doctor Primas could not provide any additional information relevant to the death investigation.

At 1330 hrs on Tuesday the 27th of May I conducted a taped interview with Emilie Beck RN D.O.N. Beck did not provide any additional information pertinent to Hubbs Death. The interview ended at 1413 hrs.

All the tapes from the interviews completed were dropped into evidence at the Sheriff's Office. The original affidavits for the warnings of constitutional rights were also dropped into evidence.

In essence Ruth Hubbs had been arrested by the Leon County Sheriff's Office and the Tallahassee Police Department on numerous charges. The charges stemmed from Ruth Hubbs breaking into convenience stores throughout Leon County. Ruth Hubbs was booked into the Leon County Jail on 04-08-2002 and was awaiting trial. Ruth Hubbs also had a hold on her for another county in south Florida.

On Wednesday the 14th of May 2003 Ruth Hubbs was moved down to the medical unit. On the morning of Friday the 16th of May 2003 at or around 0440 hrs. Ruth Hubbs was discovered deceased on the floor in her cell. After life saving measures were attempted Ruth Hubbs was pronounced deceased at 0505 hrs. by the paramedics. At the conclusion of the autopsy an exact cause of death could not be determined. The results from the toxicologist screening have not been received at the time of this report.

SCENE

Medical Unit (cell 520-B) Leon County Jail
535 Apple Yard Drive
Tallahassee, Florida 32304
850-922-3500

MEDICAL HISTORY

Ruth Hubbs had been admitted to the medical unit within the Leon County Jail on Wednesday 14th of May and had spent two days there prior to her death. Ruth Hubbs had been sent to medical based on the fact that she was not able to get up off of the floor. Hubbs also was having problems with her speech patterns and her ability to make rational statements. For further details concerning Hubbs medical conditions her medical chart can be accessed.

EVIDENCE

Fifteen (15) cassette tapes involving taped interviews with correctional staff and employee's of Prison Health Care. Twelve (12) affidavits of Warning of Constitutional Rights.

VICTIM

Ruth M. Hubbs W/F 09-10-1963 (37 year's old)
LKA: 1601 Pepper Drive
Tallahassee, Florida 32304
Spin # 148608

WITNESS / OTHER

Correctional Officer Mason Batson W/M 04-01-1970
Leon County Jail

Correctional Officer Robert Chambers W/M 06-21-1960
Leon County Jail

Correctional Officer Christopher Jacobs W/M 03-31-1970
Leon County Jail

Correctional Officer Pamelia Hawkins B/F 03-01-1971
Leon County Jail

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: 03-082193 Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

WITNESS / OTHER CON'T

Correctional Officer Lt. Larry Wilson B/M 10-07-1952
Leon County Jail

Correctional Officer John Keller man W/M 04-13-1968
Leon County Jail

Correctional Officer Velveeta Davies B/F 09-20-1971
Leon County Jail

Correctional Officer Jacquline Tillman B/F 02-02-1966
Leon County Jail

Correctional Officer Cynthia Finn W/F 04-22-1953
Leon County Jail

Correctional Officer Sgt. Bill Parramore W/M 09-08-1962
Leon County Jail

Correctional Officer Lt. Liz Black W/F 11-06-1949
Leon County Jail

Correctional Officer Clete King W/M 09-12-1970
Leon County Jail

Doctor Primas B/M 12-16-1944
Prison Health Care systems
Leon County Jail

Emilie Beck RN D.O.N W/F 03-09-1940
3991 Four Oaks Blvd.
Tallahassee, Florida 32311
850-656-8107

Lurline B. Good-Brown RN B/F 12-29-1967
1550 Payne Street
Tallahassee, Florida 32303
850-222-3376

DISPOSITION RECOMMENDED
CASE PENDING

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE		ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05 16 03	INCIDENT REPORT #	0 3 0 8 2 1 9 3

On the above date at approximatley 0445 hours I responded to medical due to Sergeant Chambers requesting assistance. Upon my arrival I was directed to room #520 B, as I entered the room I observed Sergeant Chambers attempting to pick an inmate off the floor (Inmate Hubbs, Ruth # 148608).

I proceeded to the northeast corner of the room and began to assist Sergeant Chambers. It took myself, Sergeant Chambers, Officer Christopher Jacobs and Officer John Kellerman to remove her from the floor and place her on her bunk.

After placing her on her bunk, I noticed that her face was black/blue in color.

On site medical staff began to perform C.P.R.

At this time I exited the room and began to ensure the proper personnel was notifed.

Affiant Signature: T. Tyler Buck Tyler Buck

Sworn to and subscribed before me this _____ day of _____, 19____

___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
T. Tyler Buck Tyler Buck	64	16 MAY 03		OF
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
Kim Petersen	15			

FMI (11/87)

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03082193** Victim Name(s): **Ruth Hubbs** Date Reported:

Officer Reporting: **David Graham** ID#: **283** Date: **090303**
Officer Reviewing: Sgt O'Hair ID#: 118 Date: 9-4-03
Offense(s): **Death Investigation**

Case Status: _ . ___ UCR Clearance: . . __ Date Cleared: 090403 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Wednesday, 03 September 2003, I made contact with Dr. Sadat Mansouri at the Florida State Hospital via telephone. Dr. Mansouri is the former psychiatrist for the Leon County Jail and the former attending psychiatrist for Ruth Hubbs.

Dr. Mansouri was asked specifically why Hubbs was taken off of the medication Prozac and prescribed the medication Sinequan (Doxepin). Dr. Mansouri indicated that all of my questions would be answered if I read her medical chart at the jail. I indicated to Dr. Mansouri that the Sheriff's Office had reviewed Hubbs medical chart and that our intentions for these questions are to clarify why he changed Hubbs medications and later increased the dosage of this medication.

Dr. Mansouri stated that "patients" sometimes experience insomnia as a side effect of taking Prozac. He would have then stopped this medication and prescribed her Sinequan, which would help the patient sleep. I then asked Dr. Mansouri why he ordered an increase (March 08, 2003) in the Sinequan medication for Hubbs from 50 mg. in the morning and 100 mg. at night to 100 mg. in the morning and 150 mg. at night.

Dr. Mansouri stated that the increase was probably due from the patient complaining that she was still experiencing depression. He further indicated that up to 300 mg. of this medication per day was within normal prescribed dosage.

I asked Dr. Mansouri why Hubbs was prescribed Sinequan, which is considered an older medication verses a newer anti-depressant medication.

Dr. Mansouri stated that the newer medications were more expensive and it was "their" policy not to prescribe the newer more expensive medications. When asked who "their" policy was, he indicated the medical provider at the jail. He stated newer medications could be prescribed after a tremendous amount of paper work, which was rarely if at all done.

Dr. Mansouri declined to comment on Hubbs diagnosis without reviewing her medical chart, which he agreed to do at this agencies request.

WITNESS

Dr. Sadat Mansouri, Hm# 671-3837 - cell# 228-4375
3211 Emerson Lane
Tallahassee, Florida
Former LCSO Detention Facility Psychiatrist

DISPOSITION RECOMMENDED

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03082193** Victim Name(s): **Ruth Hubbs** Date Reported:

Officer Reporting: **David Graham** ID#: **283** Date: **090303**
Officer Reviewing: _____ ID#: 118 Date: 9-9-03
Offense(s): **Death Investigation**

Case Status: _____ UCR Clearance: _ _ _ Date Cleared: 090903 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday, 05 August 2003, I made contact with Dr. Sadat Mansouri at the Florida State Hospital in Chattahoochee, Florida.

On arrival, Dr. Mansouri reviewed his medical notes within Hubbs medical chart. Dr. Mansouri indicated that on 09 February 2003, a former detention facility physician (unknown name) discontinued Hubbs Prozac medication and started her on Sinequan (50 mg in the morning and 100 mg at night). Dr. Mansouri said 08 March 2003 was his first encounter with Hubbs. At that time he increased her Sinequan medication to 100 mg. in the morning and 150 mg. at night, due to a depressive disorder.

On 23 March 2003, he diagnosed Hubbs as being bi polar. Hubbs was complaining of mood swings and continued depression. He prescribed her Lithium to be dispensed at 600 mg twice daily along with the Sinequan.

On 06 April 2003, Hubbs complained of hand tremors, which he said is a side effect of the Lithium. He lowered the dosage of the Lithium to 300 mg in the morning and 600 mg. at night. He also ordered her Lithium level checked in one week.

On 19 April 2003, Hubbs complained of continued mood swings and stated that she stopped taking the Lithium because of nausea and flashes. He discontinued the Lithium and continued the Sinequan at it's prescribed dosage. He added the medication Depakene to Hubbs medications and ordered it to be dispensed at 500 mg. twice daily. He again ordered a check of medication levels in one week due to the Depakene. He also ordered a thyroid profile, CBC with differential, and a uranalysis. He noted during this visit that Hubbs complained of hallucinations and of hearing voices. This was the last time he saw Hubbs.

Dr. Mansouri was asked if the Sinequan medication would build up toxic levels after taking it over a period of time. He stated, "no", but the Lithium and Depakene would build up over a period of time in the blood and that is the reason he orders these levels checked on a weekly basis.

Attached is a copy of Dr. Mansouri's medical notes.

DISPOSITION

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

Officer Reporting: **Detective James F. Giordano** ID#: **224** Date: **09-04-03**

Officer Reviewing: _____ ID#: 118 Date: 9-9-03

Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Tuesday 07-29-03 I received a copy of an Autopsy Report completed on deceased subject Ruth Hubbs. Hubbs was an inmate at the Leon County Jail and was found deceased in her Jail cell. At the time of her death she was being housed in the Medical Unit at the Jail complex.

One of the findings in the report indicated that Hubbs had "Doxepin intoxication. Blood Doxepin quantitation: 3.9 mg/L." Hubbs while an inmate at the County Jail was prescribed the drug Doxepin along with several other medications. In a follow up phone conversation with Doctor Mahoney he indicated the following to me. He said that a subject taking the drug Doxepin should have a therapeutic level of Doxepin in their blood system of .02 mg/L.

On Thursday 07-31-03 I delivered a complete copy of Ruth Hubbs medical chart to Doctor Mahoney at his request. That medical chart was obtained from Prison Health Services. Prison Health Services is the medical provider for inmates at the Leon County Jail. I also presented to Doctor Mahoney a set of questions concerning the Doxepin Intoxication Levels reported in the Autopsy findings. On or around 08-08-03 I received back from Doctor Mahoney his reply to the questions, (See attached copy of the questions and his answers). Arising out of the findings from the autopsy results additional interviews were set up with some of the medical staff at Prison Health Services at the Leon County Jail.

After obtaining information that Hubbs had Doxepin intoxication, I spoke to Sue Cole the administrator of Prison Health Services. I inquired about how medications are obtained for an inmate at the Jail. Sue Cole said that when medications are prescribed the following procedures are followed. The prescription is faxed to Secure Pharmacy Plus Inc. They fill the prescription and then ship it over night back to Prison Health Services. I inquired as to what is done with medications left over when an inmate leaves the Leon County Jail. Sue Cole said that all medications not used by an inmate at the Leon County Jail are sent back to the pharmacy for a credit if they can be reused. On Thursday 08-14-03 I received a copy of the medications belonging to Hubbs that had been sent back to Secure Pharmacy Plus. This information was obtained from Sue Cole at Prison Health Services.

I called Secure Pharmacy and spoke to a Jean Byassee the general counsel for Secure Pharmacy Plus. I requested a copy of the last shipment of medications that Ruth Hubbs got filled at the request of Prison Health Services. I also received a copy of the last medication shipment made for Ruth Hubbs. (See attached information.) Also attached is a copy of the medication administration training policy and procedures for Prison Health Services, Inc.

A study of the above mentioned information concerning medications requested, shipped and then returned for Ruth Hubbs provided the following results. On Friday 05-09-03 two orders of Doxepin were filled. One was for 50 mg.(30 count blister pack) prescription # 3970158 and another was for 75 mg.(30 count blister pack) prescription # 3970173.

By using the medication administration record sheet (M.A.R'S) for Ruth Hubbs it showed that she was given the following medications from 05-09-03 until 05-16-03 at the time of her death. On 05-09-03 Ruth Hubbs took one dose of 100 mg. of Doxepin. From 05-09-03 until 05-15-03 Ruth Hubbs took seven doses of 150 mg. of Doxepin. On 05-12-03 and 05-14-03 Ruth Hubbs took a dose of 50 mg. of Doxepin for a total of two doses.

In reviewing the records of the medications shipped back to Secure Pharmacy Plus it showed the following. A partial pack of Doxepin 50 mg. (27 count) prescription # 3970158, a partial pack of Doxepin 100 mg. (29 count) prescription # 3824634, and a full blister pack of Doxepin 75 mg. (30 count) prescription # 3970173 were shipped back on 05-19-03.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

In review of all the records compiled since 05-09-03 through 05-16-03 concerning the medications of Ruth Hubbs the following information was obtained. The blister pack shipped back containing the 30 count of 75 mg. Doxepin prescription # 3970173 is the same blister pack shipped on 05-09-03. The blister pack containing the 100 mg (29 count) of Doxepin prescription # 3824634 shipped back was missing one 100 mg Doxepin believed to have been taken on 05-09-03 by Ruth Hubbs. The blister pack containing the 50 mg of Doxepin (27 count) prescription # 3970158 sent back, amounts for a total usage of 150 mg. This prescription was filled on the 05-09-03. The total unaccounted amount of mg's of Doxepin taken by Ruth Hubbs since 05-09-03 is 900 total mg's. At this time it is unknown which prescriptions those 900 mg's came from. It is not possible to ascertain this information due to no inventory being done on the medication carts.

A taped interview was conducted with Registered Medical Assistant Nadine Thomas on 08-28-03. Nadine Thomas was one of the medical staff that had signed a medication administration record in the last days of Hubbs incarceration. The interview started at 1440 hrs and ended at 1503 hrs. The interview was conducted in the medical unit at the Leon County Jail. Present at the interview was Susan Cole, Harry Knight an investigator with the Department of Health, and Catherine Chapman the legal council for Prison Health Services.

Nadine Thomas said that when she comes to work she is given a set of keys to the medication cart where she obtains medication. She is the only one assigned the keys for that shift and she keeps them on her person the entire time she is working her shift. Nadine Thomas said that she follows the same procedure every time she dispenses medication to an inmate. She looks at the medication chart for the inmate and then places the medication into a 1 oz paper cup. After all the medication for a particular pod is filled the cups are secured in the medication cart. This all takes place in the pharmacy in the medical unit in the jail. The medication cart is then taken to the pods and the inmates line up to have their medications dispensed to them. The arm bands of the inmates are checked and then the pills are floated with water. Floating with water means to cover the pill(s) with water prior to the inmate taking them. Nadine Thomas said she then asks the inmate to open their mouth and she does a visual inspection to see if the inmate has swallowed the pill(s). Nadine Thomas said she learned this procedural process through training at the jail and she had to pass an evaluation period before she was signed off and allowed to work on her own in the medical unit at the Jail. Nadine Thomas said she had two opportunities to meet and see Ruth Hubbs. On one occasion she dispensed medication to her while she was in the pod. The other time was after she did a triage of Hubbs while she was in the pod. After that triage, Thomas sent Hubbs down to medical for further evaluation. Nadine Thomas then went down to the medical unit and administered to her the required medications.

An interview was done with Registered Medical Assistant Amanda Brundidge on Thursday 08-28-03. The interview took place in the medical unit at the Jail. The interview was started at 1508 hrs and ended at 1520 hrs. Amanda Brundidge was one of the medical staff that had signed the (M.A.R'S) for Ruth Hubbs. Amanda Brundidge indicated she worked the day shift when she administered medications to Hubbs. Amanda Brundidge said that she follows the same routine when she is administering the medications to the inmates.

Amanda Brundidge said that she pulls the required medications as indicated from the M.A.R's. She uses the same procedures as Nadine Thomas in filling the medications.

Amanda Brundidge said she was trained to do this by other staff members at Prison Health Services. She also said she had gone through a sixty day probation period at the beginning of her training period.

Amanda Brundidge said that she did not remember anything special about Ruth Hubbs. She did not remember seeing her in any kind of situation requiring specialized medical attention.

I conducted an interview with Registered Nurse Assistant Katherine Bratcher on 08-28-03. The interview started at 1531 hrs and ended at 1545 hrs. The interview was conducted in the medical unit at the Leon County Jail complex. Katherine Bratcher indicated that she administered Ruth Hubbs medication as per indicated from the M.A.R's sheet. Katherine Bratcher said she uses the same procedure every time she dispenses medication to an inmate. She did indicate that she does not check every inmates mouth after each administration of medications.

Katherine Bratcher said that she had seen Ruth Hubbs for the last time when she was in the M pod. She had been notified that Hubbs had been sitting on the floor in her cell. Katherine Bratcher said she was in the process of coming down to get the Charge Nurse but a Lieutenant had came down and made notification to the Charge Nurse.

L[redacted]N COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-16-03**

I interviewed Licensed Practical Nurse Loretta Hamilton on Thursday 08-28-03 and it started at1555 hrs. The interview ended at 1616 hrs. Loretta Hamilton indicated that she had administered medications to Hubbs on more than one occasion. Said she is responsible for giving out the medication when an inmate is in the infirmary. She said that when she administers medication to inmates she does it the same way every time. She said that if she noticed an inmate having problems taking medications she will have the inmate return the medication cup and they start the process all over.

Loretta Hamilton said that on the day Ruth Hubbs was moved down from the pod to the infirmary she was the nurse that did the evaluation on her. Hamilton said that Sgt. Parramore and Lt. Liz Black came to her and said that they had an inmate in one of the pods that was not acting right. Hamilton said that Hubbs was acting strange and she felt that it was necessary to move Hubbs to the infirmary. Hamilton said she had Hubbs put in an observation cell in the medical unit.

DISPOSITION RECOMMENDED
PENDING

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-21-03**

Officer Reporting: **Detective James F. Giordano** ID#: **224** Date: **09-10-03**

Officer Reviewing: Sgt. C Plummer ID#: 118 Date: 9-11-03

Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Monday 09-08-03 I conducted a taped interview with Registered Medical Assistant Matilda Frazier at the Leon County Jail. The interview was concerning her involvement in the Ruth Hubbs death investigation. The interview was started at 1520 hrs and concluded at 1541 hrs. Matilda Frazier indicated that she had the opportunity to issue Hubbs medication as identified in the medication administration record sheet. She said that she follows the same procedure every time when she issues the medications to the inmates. Matilda Frazier also said that if an inmate is out of medication she can check out medication from the pharmacy. When the Medications are checked out, they then go into a container which stays on the medication cart. Matilda Frazier said that the slips used to check out medication from the pharmacy are kept in the pharmacy on a clip board.

Matilda Frazier said she had the opportunity to see Hubbs in the infirmary. Hubbs had been sent down to get checked out in the infirmary. Matilda Frazier said she had administered medications to Hubbs while she was in the infirmary.

On the same date I conducted a taped interview with Paramedic/ Critical Care Specialist Bob Roddenberry at the Medical Unit at the jail. The interview started at 1541 hrs and concluded at 1600 hrs. Roddenberry said he had the opportunity to issue medication to Hubbs on Sunday 05-04-03. He said that he only gave Hubbs one of her required medications, he said he did not issue the other medication. This was because he had working knowledge about Hubbs possibly "cheeking her medications." This information had been passed on to him from the day shift medication nurse (possibly Nadine Thomas).

Later in the day Bob Roddenberry was contacted by Sgt. Plummer who called him and said that Hubbs was acting strange. Hubbs was brought down to the medical unit. He said she was acting as if she was sedated.

Bob Roddenberry said that when he issues medication he uses the same procedure every time. His procedures are similar to that of Matilda Frazier. He said that if there are medications that an inmate might be out of he can get extras out of the pharmacy. When medications run out, additional medications are taken out of the bulk supply from the pharmacy. Those drugs are signed for by the person issuing the medications. The medications are then assigned to the particular medication cart the subject is operating. He said that if the medications come in the next day for a particular inmate the medications that where taken out of the pharmacy stay in the cart.

EVIDENCE

Six (6) cassette tapes involving taped interviews with staff of Prison Health services.

WITNESS INFORMATION

Susan Cole W/F 09-19-1951
Health Care Administrator, Prison Health Services
Leon County Jail
850-922-3562 (Wk)

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-21-03**

Harry Knight W/M 11-27-191944
Investigator, Division of Medical Quality Assurance
Florida Department of Health
4052 Bald Cypress Way
Tallahassee, Florida 32399
850-922-2709 (Wk) 850-414-2832 (Wk)

Catherine Chapman W/F 05-20-1973
General counsel for Prison Health Services
Attorney At Law.
Andrews, Crabtree, Knox & Andrews, LLP
1558 Village Square Blvd. 32309
850-297-0090 Ext 146 (Wk)

Doctor John Mahoney W/M 05-20-1948
Assistant Medical Examiner
Pathology Associates Inc.
1899 Eider Ct
Tallahassee, Florida 32309
850-942-7473 (Wk)

Nadine Thomas B/F 01-11-1969
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Amanda Brundidge B/F 08-20-1973
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Katherine Bratcher B/F 01-22-1965
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Loretta Hamilton W/F 12-09-1944
Licensed Practical Nurse
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth** Date Reported: **05-21-03**

Matilda Frazier B/F 01-20-1965
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Bob Roddenberry W/M 10-28-03
Paramedic / Critical Care Specialist
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

SUMMARY:

On Friday 05-16-03 I was notified of the death of an inmate at the Leon county Jail. The inmate (Ruth Ann Hubbs) was being housed in the medical unit at the jail. She had been moved out of the general population due to strange behavior. It was indicated that she was having trouble walking and that her speech was slurred. She also was said to have been talking to herself. Hubbs was found deceased in a cell in the medical unit. Life saving measures were done and she was pronounced deceased. An Autopsy was done and no obvious signs of injury or causes of death were noted.

Toxicologist results showed that she had an intoxicating level of the medication Doxepin in her system. Doxepin was one of the medications Hubbs had been prescribed while an inmate. After the results from the Autopsy were made available interviews were completed with the staff from Prison Health Services. After interviews with staff from Prison Health Services I am unable to determine how Hubbs received an intoxicating level of Doxepin in her system.

DISPOSITION RECOMMENDED
PENDING

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: 03-82193 Victim Name(s): Ruth Hubbs Date Reported: 05-16-03

Officer Reporting: Curtis Parker ID#: 117 Date: 04-02-04

Officer Reviewing: Lt. [signature] ID#: 70 Date: 4-2-04

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 03-30-04 Emily Beck voluntarily responded to the Violent Crimes Unit at the request of Det. David Graham. This writer interviewed Ms. Beck as Det. Graham was unavailable that day. Ms. Beck had previously been interviewed regarding the Hubbs death investigation by Det. Giordano and Health Department Investigator Harry Knight. These prior interviews occurred in 2003. Ms. Beck had been employed as the Director of Nursing for Prison Health Services at the Leon County Jail at the time of Ms. Hubbs death. Ms. Beck advised sometime prior to her death Ms. Hubbs and two other inmates had been suspected of "storing"medications. Ms. Beck could not advise who the other inmates were or who provided the information alleging they were storing medications and sharing them among each other. This was Ms. Beck's first contact with Ms. Hubbs.

Ms. Beck also advised she had been repeatedly contacted by Ms. Hubbs attorney Steven Glazer who was requesting Ms. Hubbs medical records. According to Ms. Beck, Mr. Glazer was attempting to have Ms. Hubbs placed in some type of treatment facility and needed her medical records to do so. Ms. Beck stated she thought Mr. Glazer had been sent the medical records, but apparently that was not the case as he had received nothing. Ms. Beck then spoke with PHS Administrator Sue Cole who stated she would take care of sending Ms. Hubbs medical records to her attorney.

Ms. Beck advised when Ms. Hubbs was placed in the medical unit for the final time prior to her death she visibly deteriorated. Ms. Beck stated she spoke with Dr. Primus about Ms. Hubbs condition and requested he intervene. According to Ms. Beck, Dr. Primus responded that Ms. Hubbs was a psychiatric patient and not his responsibility. Ms. Beck stated many people were concerned about Ms. Hubbs condition, but she was being treated by psychiatry and they were having difficulty getting a psychiatrist on site. Sue Cole was reportedly conferring with psychiatrist Dr. Larranaga (in Pensacola) via telephone. Ms. Hubbs was on a list to see Dr. Larranaga, however she was way done the list and did not see him when he actually came to the facility approximately one week prior to her death.

Ms. Beck went on to say she submitted her resignation to PHS on 05-08-03 because she could not get anything done for inmates. Ms. Beck was required to work an additional 30 days after submitting her resignation. She further stated she lost her effectiveness and people were not listening to her and in her words were, "blowing her off". She described the working conditions at PHS as very bad at that time. When asked what it would have taken for Dr. Primus to treat Ms. Hubbs, Ms. Beck agreed it would have taken Ms. Hubbs going into cardiac arrest or something similar for her to receive medical treatment. Again, this demeanor on the part of Dr. Primus was because Ms. Hubbs was a psychiatric patient and not a medical patient.

In describing how often Dr. Larranaga met with patients at the Leon County Jail Ms. Beck stated he did so approximately once every two weeks. Dr. Larranaga reportedly met with approximately 30 patients each time he came to Tallahassee (in a one day period). Ms. Hubbs reportedly, as stated earlier was more than 30 people down the list to be seen by Dr. Larranaga. Ms. Beck advised in reviewing Ms. Hubbs chart when she attempted to have her treated by Dr. Primus she observed numerous entries in the medical file documenting correspondence between Sue Cole and Dr. Larranaga in which they were attempting to treat Ms. Hubbs via telephone correspondence. The entries observed by Ms. Beck reportedly included medication changes etc.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03-82193 Victim Name(s): Ruth Hubbs Date Reported: 05-16-03

These alleged entries Ms. Beck states were in Ms. Hubbs medical file are no longer present.

Ms. Beck then stated Dr. Primus would withhold all of a patients prescribed medication if they refused to take a particular medication. According to Ms. Beck, Dr. Primus told patients they would do what he said or receive nothing. Ms. Beck considers this behavior to be unethical. She stated she was "outraged" by this behavior by Dr. Primus. She further stated this tactic by Dr. Primus was common knowledge of PHS employee's. She stated this was a major factor in her decision to resign from PHS.

Ms. Beck described a contact with Sgt. Joyce McCary shortly before Ms. Hubbs death. Sgt. McCary contacted Ms. Beck and told her she felt Ms. Hubbs condition was getting worse. Ms. Beck told Sgt. McCary she agreed with her and had talked to Sue Cole, "until she was blue in the face" and to Dr. Primus and had been unable to get anyone to treat Ms. Hubbs. Sgt. McCary then asked Ms. Beck to speak with Sue Cole again in an effort to get Hubbs medical treatment. Ms. Beck agreed to do so and went to speak with Sue Cole. Ms. Beck told Sue Cole that Ms. Hubbs was deteriorating and getting worse. In addition, she told Sue Cole that Ms. Hubbs attorney was trying to get her out of jail and in a treatment facility and still had not received Hubbs medical file. Sue Cole reportedly replied(without looking up from her desk), "Give me the chart, I'll take care of it". Ms. Beck placed the chart on Cole's desk and at that time she observed approximately 2 pages of medical orders done by Cole in phone consultation with Dr. Larranaga in Pensacola. Ms. Beck then left Cole's office. She returned to Sgt. McCary and told her she was getting nowhere with obtaining treatment for Ms. Hubbs.

This writer asked Ms. Beck why she couldn't have summoned an ambulance for Ms. Hubbs in light of the fact the doctor and PHS Administrator were refusing to treat Ms. Hubbs. Ms. Beck replied that she could not do so without the approval of her superiors. She stated she was required to go through the "chain of command"and failure to go through the proper channels would result in her being fired. It also could affect her nursing license according to Ms. Beck.

Ms. Beck advised she was not aware of any lab work ever being ordered or done for Ms. Hubbs. She stated she asked Dr. Primus for some lab tests for Ms. Hubbs and "he blew me off". Ms. Beck stated she had looked in Ms. Hubbs medical chart and could find no orders for lab work on Ms. Hubbs prior to going to Dr. Primus. At a later date Ms. Beck stated she observed where an unknown person inserted a request for lab work on Ms. Hubbs that had not previously been in Hubbs medical file. Ms. Beck could not determine who wrote the lab request as the handwriting is not familiar and the signature could not be read. Ms. Beck feels this was a fictitious entry in the medical file. The fact no lab work was ever done on Ms. Hubbs supports Ms. Becks assumption. Ms. Beck further advised it is not possible for an inmate to not "show up" for lab work as is alleged by PHS.

In regards to missing medical file entries made by Nurse Rebecca Mohrman and Robert Roddenberry, Ms. Beck stated she did not observe either Mohrman or Roddenberry place notes in Hubbs medical file. She did observe Mohrman writing the notes in her office. In regards to Roddenberry, Ms. Beck had a telephone conversation with him in which he told her he was withholding Ms. Hubbs medication because he thought she was overmedicated. Ms. Beck stated she told Roddenberry to document what he was doing and place the documentation in Ms. Hubbs medical file. She believes Roddenberry did so.

In regards to protocol's reportedly being violated Ms. Beck confirmed PHS utilizes Clorox bleach to treat fungus problems instead of the preferred fungal creme. She believes this is done as a cost saving measure even though fungal creme reportedly is not very expensive. Ms. Beck advised protocol's are very important because they explain how to treat various problems. She stated she had been attempting to establish protocol's at PHS , but they in large part had not been enacted. She reportedly encountered resistance in this area from Dr. Primus. She believes Dr. Primus compensation is tied into PHS profit margins, however she does not know this

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03-82193 Victim Name(s): Ruth Hubbs Date Reported: 05-16-03

for a fact. This writer contacted LCSO Chief Administrator Captain Scott Bakotic and asked if he knew if Dr. Primus compensation was related to PHS profits. Captain Bakotic stated he did not know, but did not think it was likely.

In summary, Ms. Beck had submitted her resignation to PHS on 05-08-03, but was required to work an additional 30 days. Ms. Beck advised she had ceased communicating with her superiors and felt PHS was doing a poor job treating inmates. Ms. Beck observed Ms. Hubbs deteriorate during her time in the medical unit and attempted to get Sue Cole and Dr. Primus to treat Ms. Hubbs without success. Ms. Beck observed orders in Ms. Hubbs medical file detailing correspondence between Sue Cole and Dr. Larranaga regarding Ms. Hubbs treatment. That correspondence is now missing from Hubbs medical file. Ms. Beck observed nurse Rebecca Mohrman writing an entry for Ms. Hubbs medical file which is now missing from the file. Ms. Beck had a conversation with Robert Roddenberry in which he told her he was withholding Ms. Hubbs medication due to her behavior. Ms. Beck told Roddenberry to document his actions. Roddenberry's report is missing from Hubbs file. Ms. Beck also believes an unknown person made a fictitious entry in Hubbs file ordering lab work. Dr. Primus refused to treat Ms. Hubbs because she was a psychiatric patient and not his responsibility. Sue Cole was asked repeatedly to intervene in Ms. Hubbs treatment, but according to Ms. Beck did nothing. Ms. Beck believes Ms. Hubbs death was preventable and that she received substandard care while in the custody of PHS.

DISPOSITION RECOMMENDED

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:

Agency Report Number: 03082193 Victim Name(s): **Ruth Hubbs** Date Reported: **051603**

Officer Reporting: **David Graham** ID#: **275** Date: 050804
Officer Reviewing: [signature] ID#: 117 Date: 5-9-04
Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday, 16 May 2003, Violent Crimes Detective James Giordano investigated the death of Ruth Hubbs, who was an inmate at the Leon County Jail.

Detective Giordano's investigation revealed that Hubbs was discovered deceased in a medical holding cell at or around 0440 hours on the above date. Life saving measures had been initiated by medical staff and paramedics who responded to the scene, without success. Responding paramedics pronounced Hubbs deceased at 0505 hours.

Hubbs was found laying on the floor at the foot of her cell's bed, face up with her head toward the south and her feet toward the north.

During Detective Giordano's initial interviews, it was revealed that several of the medical and correctional staff attempted to have Hubbs seen by medical staff due to behavior indicating she was being "over medicated". Medical records do not indicate any type of preventive intervention was ever taken.

No criminal conduct was discovered during Detective Giordano's investigation.

During an Administrative Investigation conducted by Investigator Harry Knight of the Department of Health, he contacted expert witness Professor Paul Doering of the University of Florida College of Pharmacology.

Doering reviewed Hubbs autopsy/toxicology report and a copy of the LCSO investigative report. Doering concluded based upon the information he received, that in all probability it took more than ten doxepin pills to cause Hubbs death. He added it was impossible to know exactly how many pills it would have taken to cause death, but the level of doxepin in Hubbs blood was toxic. This information was based on the strength of the pills, the weight of the patient and the information in the above named report. Doering advised had the patient taken all her medication as prescribed there woud not have been a negative outcome. Doering also stated, in his opinion, had there been an evaluation by the doctor at the time requested, the patient would have probably been saved.

Investigator Knight also interviewed several employees of Prison Health Services (PHS). These interviews revealed PHS employees were screening and counseling inmates for psychiatric reasons without licensure through the State of Florida. The investigation also alleged missing medical documents from Hubbs medical file and PHS employees who were concerned for Hubbs well being.

Investigator Knight's interview with Prison Health Services (PHS) employee Natasha Carr revealed that she was employed as a mental health clinician and that she was not licensed in Florida and did not have to be. Carr was responsible for the mental health screening of inmates, making referrals to Psychiatrists, as needed, and mental health counseling upon request.

Based on the information provided in Investigator Knight's report, PHS employees Natasha Carr, Rebecca Mohrman, Robert Roddenberry, Robbie Hilliard, and Nadine Thomas were served with witness subpoenas for reinterview by this writer. These interviews took place at the State Attorney's Office.

On Monday, 29 March 2004 at approximately 1330 hours Sgt. Curtis Parker and I interviewed Natasha Carr at the State Attorney's Office. Carr was placed under oath by Chief State Attorney Warren Goodwin, who was also present during the interview. Carr is and was employed by Prison Health Services as a Mental Health Clinician. She is responsible for mental health screening, making referrals to psychiatrists, and mental health counseling of inmates upon request. Carr advised she was not licensed in the State of Florida to perform these mental health services and did not have to be.

Carr recalled one occasion in May of 2003, when she was escorted by Sgt. McCary to the holding cell in the infirmary where Hubbs was being held. Carr stated that it was common for officers to request that she speak with patients being held in the infirmary who are on psychotropic medications. When they arrived at Hubbs cell, Hubbs was sitting on the floor without her pants on, she would not verbally communicate. Carr asked her to put her pants on, Hubbs picked them up, looked at her (Carr) looked at the pants and then put the pants down. Based on Hubbs behavior, Carr placed Hubbs on a list of patients to see the psychiatrist, who at the time was Dr. Larranagga. Dr. Larranagga's office is based in Pensacola, Florida.. Per Carr, as a mental health clinician she could not personally take orders from the psychiatrist. She would report her findings to her supervisor, who is registered nurse Sue Cole. Cole would in turn report these findings to the psychiatrist who would then prescribe medications based on reported behavior. Carr advised she does not know if Dr. Larranagga physically saw Hubbs after her request. Carr advised that Dr. Larranagga was filling in as the psychiatrist for the Leon County Detention Center. Because Dr.Larranagga was based in Pensacola, there was occasion when she reported her findings to Sue Cole, Sue Cole would relay these findings to Dr. Larranagga, who would in turn prescribe medications based on reported behavior.

Carr advised that on one occasion when she reported Hubbs behavior to Sue Cole, Cole stated "She's putting on quite a show". Carr further stated that Cole, even after making the above statement, was concerned about Hubbs behavior. Carr could not provide any further information.

On Monday, 29 March 2004 at approximately 1411 hours, Sgt. Curtis Parker and I interviewed Rebecca Mohrman at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Mohrman advised that she is employed as a Registered Nurse by PHS. She is responsible for "histories" and "physicals of inmates" at the jail.

Mohrman said in May of 2003 she had an occasion to see Hubbs. She and Emily Beck, Director of Nursing during this time, were asked to assist officers with Hubbs, who had fallen down. Mohrman said that Beck resigned from her position, Director of Nursing. Mohrman said that Beck resigned because she no longer felt comfortable working for PHS and that "it was a train wreck ready to happen". When Mohrman was asked if she knew what Beck meant by "it was a train wreck ready to happen", Mohrman replied, "I already knew what she meant". Mohrman said that "it just wasn't a team", "it was very difficult to get everyone to work together". When I asked Mohrman why it was very difficult for everyone to work together, she became very visibly upset. She said that it was very difficult for her to say what was going on, because she still works for this company, she enjoys working for this company and she enjoys her job. She continued by saying that she doesn't like saying anything negative about her company. Mohrman began crying at this point and was asked by the attorney representing PHS if she needed a break. Mohrman stated emotionally that she did not know that PHS's attorney would be present during the interview. The interview was temporarily stopped at this time.

After approximately 15 minutes, Mohrman returned to the conference room with PHS's attorney. Mohrman's demeanor noticeably changed after talking with the attorney. Mohrman became very vague in her answers, almost to the point of being defensive.

At this time the line of questioning was changed. Mohrman was asked if she had ever documented anything in Hubbs medical file. She replied, "yes". She stated she documented the incident when Hubbs had fallen and how she was behaving at the time of this incident. Mohrman was then asked if she had the opportunity to look at Hubbs file at a later date. She answered, "Yes". During an interview with Mr. Knight, Mohrman was shown Hubbs file. Mohrman asked Knight, "Where's the rest of them?". She indicated to Knight that the file was incomplete and that her documentation of Hubbs' fall and condition were missing from the file, and that the file looked "different". Mohrman advised that any and all documents placed in a patient/inmates medical file is permanent and should never be removed.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION Original: Supplemental: X Juvenile:
Agency Report Number: 03083193 Victim Name(s): **Ruth Hubbs** Date Reported: 051603

Mohrman further went on to say that around this same time (May of 2003) she had requested lab work on Hubbs because "she was talking out of her head and not acting right". Mohrman, Beck and an officer were talking about Hubbs and the way she was acting. Mohrman said that Hubbs was acting like a patient she once treated that had high ammonia levels. Beck advised her to pull Hubbs medical chart so they could see when the last time she had lab work done. After pulling Hubbs medical file, they could not see where any lab work had been ordered. Beck told Mohrman that she would have the doctor order blood work on Hubbs so they could see where she was at. Mohrman said Beck went next door and spoke with Dr. Primas about getting blood work on Hubbs. According to Mohrman, Dr. Primas told Beck that he was not going to order the labs for Hubbs. Mohrman said the labs would give them a base line showing infection, or if something was amiss. Beck further stated to Mohrman that the reason Dr. Primas didn't want to have labs run on Hubbs was because she was "a psych patient and he did not want to have anything to do with her." When Mohrman was asked why there was no lab work request in Hubbs file she advised the request from her was verbal, not written. She went on to say it's not proper protocol to ask a physician in writing for lab work, a request would not be documented in the patients file.

Mohrman said that on this particular day when she went to Hubbs cell, Hubbs was sitting on the floor, her back against the wall and her legs under the bed. When Mohrman asked Hubbs how she got on the floor Hubbs responded saying she slid on the floor, because she didn't want to roll over on the baby in her bed (the baby was a rolled up blanket in the middle of Hubbs bed). Mohrman said that Hubbs was very disoriented and was having trouble following simple commands.

Mohrman was asked, if in her opinion Hubbs was capable of "cheeking" her medication at the time she saw her, she replied, "no, she wasn't lucid. She couldn't follow simple move your foot?, much less I want to cheek these pills". Mohrman said that the mental health clinician, Natasha Carr, would see Hubbs during her rounds. Mohrman stated Carr made rounds on patients that were referred to her by the registered nurses. To clarify, here a licensed registered nurse refers patients to a non-licensed employee for mental health evaluation.

When Mohrman was asked about her working relationships she described them as very tumultuous and difficult to work during the above time period. There were problems with interpersonal relationships regarding personnel, problems with the way employees reacted to each other.

Mohrman was asked about the missing contents of Hubbs medical file. Mohrman advised that when she was shown the file by Mr.Knight her notes on Hubbs fall were missing. Mohrman was asked if she was familiar with anything Robert Roddenberry may have put in the file that was also not in the file? She stated that she remembered talking to Roddenberry at the nurses station and that he said he had stopped the medications on Hubbs. He also stated that he had documented a couple of pages on Hubbs. Mohrman was then asked if she ever observed those particular entries when she had the file in her possession. Mohrman said she and Emily Beck had gone over Hubbs file together, so they could get a base on what was going on with Hubbs, she only had her that one day and wasn't familiar with her. They both read the file and remembered there were several entries regarding Hubbs, but could not remember the individual people who wrote them. Mohrman could only advise that her notes, because the file was not in front of her at this time, were missing from Hubbs medical file.

Mohrman was asked about PHS protocol, specifically how an inmate is medically treated if he/she has a fungus on their feet or a physical problem of that area. PHS protocol calls for the use of an anti-fungal cream for treatment. Mohrman was asked to elaborate. Mohrman stated that "they" were told to use a diluted bleach spray. Mohrman confirmed that diluted bleach spray was used instead of the fungal cream because of cost (bleach costs considerably less than fungal cream). Mohrman was then asked if she was aware of any other situations similar to this, where people are supposed to be treated one way but like this example, are treated differently? Mohrman hesitated for an extended period of time and then stated she didn't know how to answer the question.

Mohrman was then asked if she knew of any other circumstances where PHS deviated from other medical protocols. Mohrman answered "yes". She then gave the example of if an inmate was brought to the infirmary for chest pain and high blood pressure. The protocol called for giving them nitro and taking their blood pressure. She advised they were told not to give them nitro, do not do an EKG, and if they felt the patient was in distress, they were to call 911, but they are not to treat them. Mohrman said this was contrary to her RN training. When asked if there were any other situations, she again hesitated. Mohrman could not explain the reason for deviating from protocol but did advise they were instructed to do so by Dr. Primas during a staff meeting. Mohrman said that both the EKG and Nitro were inexpensive. When in this staff meeting one of the nurses asked Dr. Primas why they weren't to run an EKG, EKG paper doesn't cost much, Dr. Primas responded by saying "no, it's not an arcade machine". Mohrman stated this later deviation from protocol was effective February 2004. At this point the interview was ended.

On Monday, 29 March 2004 at approximately 1540 hours, Sgt. Curtis Parker and I interviewed Robert Roddenberry at the State Attorney's Office. He was placed under oath by Chief State Attorney Warren Goodwin. Robert Roddenberry was employed by PHS as an Emergency Medical Technician in May of 2003. Roddenberry advised that in May of 2003, he was approached by a medical nurse who had informed him that Hubbs was "out of it". He later received a call from Sgt. Plummer who said there was concern for Hubbs condition. Roddenberry had Hubbs brought down and then he housed her in the infirmary. Roddenberry stated that it was clear that Hubbs was heavily medicated. This was his reason for withholding her medications that evening, however he did state she had received her meds that morning, her a.m. dose. After a period of time, her condition improved. Roddenberry advised he documented one and one-half pages of notes pertinent to her care. He advised he placed these notes in Hubbs file personally, he remembers specifically because he had to take the file apart in order to place these notes in the correct place. He further advised he was sure his documentation was lengthy because a co-worker, Robbie Hilliard, had commented on the length of his documentation, referring to it as a "book". On two later dates, once with Sue Cole and the other with Investigator Knight, Roddenberry had the opportunity to view Hubbs file. On both dates he found his documentation on Hubbs missing.

Roddenberry advised that in his professional opinion, Hubbs showed signs of being over medicated. Two signs he mentioned that caused him to believe Hubbs was over medicated was she was very slow to respond and unable to speak clearly. These are two of the symptoms he, as a paramedic, look for in a tricyclic patient. On a later date Roddenberry had an opportunity to speak with Sue Cole reference to the missing progress notes he had placed in Hubbs medical record. Roddenberry said Cole told him she didn't know what happened to them. Roddenberry stated during his employment with PHS he had never known medical files to go missing from an inmates medical record. When Roddenberry was asked if he was surprised that these documents turned up missing, he said, "it kind of identifies the problem two weeks before something bad happens". Roddenberry said that in his opinion, Hubbs problem was laid out in black and white and it looks bad that nothing was done for two weeks. Roddenberry advised that he spoke with Emily Beck about Hubbs medical condition. Beck told him that she basically "hit a brick wall" trying to get anything done for Hubbs. Roddenberry was told by Beck that she had gone to Sue Cole in an attempt to have Hubbs seen by the psychiatrist or the doctor. Roddenberry advised, that in his opinion Hubbs should have had lab work done. If Hubbs had refused lab work, it would have been documented in her medical file. Roddenberry said an inmate can't just refuse an appointment, they must physically come down, unless they are physically combative, and sign a refusal. Usually once the inmate is already down they go ahead and take their meds or have their labs drawn, whatever the circumstance. He advised for the inmate to get up and go to medical was three quarters of the battle, sometimes they just don't want to get up and go but once they are there they proceed with what they're initially sent there for. Roddenberry was again asked why he thought his notes were missing from Hubbs medical file and he replied, "it identified a problem and she was dead two weeks later, it identified a problem that appears wasn't addressed". Roddenberry further stated that this situation with Hubbs was far more than just "slipping between the cracks".

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Agency Report Number: 03083193 Victim Name(s): **Ruth Hubbs** Date Reported: **051603**

Emily Beck voluntarily came into the Sheriff's Office on 30 March 2004 and was interviewed by Sgt. Curtis Parker in my absence. (See Sgt. Parker's report)

On Thursday, 01 April 2004 at approximately 0910 hours, Sgt. Curtis Parker and I interviewed Robbie Hilliard at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Hilliard stated that she never had any contact with Hubbs. She recalled one incident where Roddenberry placed Hubbs in observation in the medical unit until she could be seen by the doctor. She said that Roddenberry told her that Hubbs was not acting normal, so he did not give her the evening dose of her medication. This is the only thing that she could recall him saying.

She went on to say that Roddenberry documented Hubbs behavior in her medical chart. She said that Roddenberry is known for his thorough documentation of patients.

Hilliard said that she has been employed by PHS since November of 2002 as a medical assistant. Currently she is assisting doctors with sick calls. She also passes out medications to patients/inmates without licensed medical personal present. Hilliard said that she is not licensed for this position, but she has had military training as a medical assistant and at one time she was licensed as an EMT, but currently she holds no medical license. She further said that she does not have a degree or certification in this position, just previous training. She could provide no other information regarding this investigation.

On Thursday, 01 April 2004 at approximately 0945 hours, Sgt. Curtis Parker and I interviewed Nadine Thomas at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Thomas advised that she is employed as a registered medical assistant with PHS. Her responsibilities are charting, scheduling appointments, chart review, vitals, taking off orders and doing chronic clinics.

Thomas said that on two different occasions she passed medications to Hubbs. She would float the medication, give it to the inmate and then make them open their mouth to ensure that they swallowed their medication.

She said that on one occasion an officer told her that Hubbs was acting strange. The officer told her that Hubbs would not get up and eat and that she was slurring her speech a little. After receiving this information from the officer, she passed Hubbs her medication and went back to the unit and called medical. Thomas said that she spoke to Cole about Hubbs behavior. Cole then called Hubbs to medical.

Thomas said that in May of 2003, she was responsible for stocking the med charts, doing vitals, stocking the rooms, working medical records and passing pills. Thomas was asked the procedure she would follow if an inmate refused medication. Thomas said that she would, "sign the book" and circle it. You also document anything that the inmate might say. Thomas was asked the procedure she would follow if an inmate refused lab work. Thomas said, "now?", if they refuse to have blood drawn. Dr. Primas would send them a letter stating various things including they are taking their care into their own hands, and she believes he gives them two weeks to respond. Thomas stated that it is not possible for an inmate to just not show up for labs. There is always some type of documentation showing refusal, either by the inmate or a refusal written by security on behalf of the inmate.

Thomas was asked if she ever heard of documentation missing from an inmates medical file. Thomas said, "yes", Roddenberry said that some of his documentation was missing from Hubbs medical file. This was the only time she ever heard of any documentation missing from any medical file. When asked if it would be unusual for documentation to be removed from a medical chart, she replied, "yes". At this time Thomas could provide no further information in regards to this investigation and the interview was ended.

In summary this investigation has revealed that Ruth Hubbs had toxic levels of Doxepin in her system at the time of her death. Concerned medical personnel observed Hubbs displaying what they perceived to be signs of being overmedicated.

One example is when medical staff requested Dr. Primas to intervene in Hubbs medical condition, his reply was, she is a psych patient and he didn't want to have anything to do with her. Labs were requested verbally, but for some unknown reason were never orderd by physicians. Hubbs behavior was documented in her medical file, however that specific documentation is no longer in Hubbs medical file.

Medical personnel stated that had the intervention been successful there may not have been a negative outcome. These interviews also revealed that PHS is deviating from their own medical protocols.

PHS has employees who are not licensed, certified or hold degrees (RN, LPN} evaluating mental health patients, counseling mental health patients, and dispensing narcotic medications to inmate patients. In one known situation, Mohrman who is an RN would report her findings to Carr who is a medically unlicensed/uncertified employee. In another situation, Robbie Hilliard who has "some" military training as a medical assistant, but is not medically licensed is dispensing narcotic medications to inmate patients in the absence of any licensed medical personnel. PHS has also had past employees resign due to the companies careless medical practices and inability to set up proper procedure practices.

According to staff, there is no inventory of meds on the medical cart. Staff also indicated that if a patients meds are changed, run out or a new medication is ordered, it is pulled from "bulk stock" (in house pharmacy) until the prescription is filled by the contract outside pharmacy. These prescriptions usually come in the following day. There is no knowledge of what happens to the extra meds placed on the cart, their expiration, or what happens to them if not used by the patient intended.

I have attempted to contact Sue Cole in reference to a follow up interview with negative results. Staff at the Leon County Jail advised that she was no longer employed at the detention facility, but she is still employed by PHS.

I have attempted to contact Dr. William Primas, via messages at the detention facility and via his attorney (Ms. Andrews), also in reference to a follow up interview.

To date, I have not been able to contact Cole or Primas.

This case is pending review by the State Attorney's Office for possible criminal charges and a potential Grand Jury review.

LEON COUNTY SHERIFF'S OFFICE

ADMINISTRATIVE INVESTIGATIVE REPORTING FORM

AIB CASE NO: A03-18

DATE RECEIVED COMPLAINT: 23 May 2003

DATE REPORT COMPLETED: 23 June 2003

COMPLAINANT: Major Carl Bennett
Leon County Jail
922-3500

MEMBER INVOLVED: Not Applicable

INVESTIGATOR: Sgt. Tim Baxter
Administrative Investigations Bureau

DISCIPLINARY STANDARD
Not Applicable

Jail Death/Administrative Review

SYNOPSIS OF COMPLAINT
At approximately 0440 hours on 16 May 2003 Inmate Ruth Hubbs, #148608 was discovered deceased in her room in the medical unit at the Leon County Jail. There were no immediate signs of foul play indicated. She was the lone occupant of the room.

INVESTIGATIVE NARRATIVE

Ruth Hubbs was incarcerated in the Leon County Jail on 22 March 2002. She has been an inmate since that date. During her time of incarceration she began to complain of depression and other type mental disorders. The appropriate referrals and inmate requests were forwarded by the corrections staff to the medical unit operated by Prison Health Services.

On 16 May 2003 at 0435 hours Ms. Hubbs was discovered deceased in her cell in the infirmary at the Leon County Jail. She was discovered by Officer Mason Batson and Nurse Lurline Brown who were conducting the passing out of meal trays. C.P.R. was initiated to no avail. The observation was made that she appeared to be "wedged" between her bunk and the wall. Due to her large size several other officers responded and at that point they were able to lift her from the floor to the bunk. After E.M.T. responded and confirmed her death the room was secured for investigative purposes. There were no immediate signs of foul play noted by responding detectives.

Following is information related to the contact Leon County Jail Staff had with inmate Hubbs on the days immediately prior to her death.

Lieutenant Liz Black

On 13 May 2003 she was making rounds. At approximately 2318 hours she went into Pod M and made contact with Correctional Officer Cindy Finn. She was also reviewing the logs. She noted that earlier in the day Correctional Officer Nora Schultheis had made a notation that inmate Hubbs had been, "crying, yelling, and had trashed her room." Lt. Black inquired of Finn how Hubbs had been acting. Finn responded that the room was still trashed, and that Hubbs had been sitting on the toilet pressing the intercom every few minutes. Lt. Black called for Sgt. Bill Paramore to come to the pod to assist her. They then responded to Hubb's room to speak to her. They observed her sitting on the floor with her legs stretched out in front of her. She was talking incoherently with slurred speech. She appeared dazed and confused, was unable to state where she was, what the date was or who the president is. She told them she had arrived at her location by "subway." They asked her what was wrong. She responded, "they changed my medication." She was unable to get herself off the floor and instead propelled herself backwards by "hopping" with her buttocks. Black and Parramore then went to medical and made contact with the charge nurse, Kathy McCabe. They informed her of Hubb's condition. Nurse McCabe told them: Hubbs was "faking to look crazy, just acting out," there was "nothing she could do for her," and that they "could bring her down to medical if they wanted to, where she could just sit on the floor in a medical cell, and act crazy."

Based on this response from a trained medical person the decision was made to leave her in the pod. However, Officer Finn was told to keep a close watch on her.

Lt. Black remained very concerned over Hubb's obvious deterioration of her mental/physical state the next day. She contacted Lt. Dan Schmidt from home at approimately 1400 hours to tell him of her concerns so the day shift could monitor on her.

Later during the evening of the 14th Lt. Black's shift returned to work. Hubb's condition had not improved and in fact she now had stopped eating. Lt. Black and Sgt. Parramore went to medical and made contact with charge nurse Hamilton. They began to express their concerns to her. A nurse standing close by (Braetcher) made a comment that she had seen these same behaviors in Hubbs. She stated Hubbs appeared to be "over medicated." Sgt. Paramore inquired of her why would you continue to give her meds if you thought she was over medicated. She replied, "she was not permitted to make that kind of decision. It's ordered by a doctor, and I can't take it upon myself to stop it." He then asked her if she had reported Hubb's condition to anyone. She responded she had reported it to "all the higher ups including Sue Cole." Nurse Hamilton then went with them to the pod to observe Hubbs. After viewing her she told them Hubbs "shows classic signs of being over medicated, and she needs to be taken to the infirmary." With the help of several officers she was carried to a stretcher and wheeled into medical. A memorandum from Lt. Black is included in this report.
End of statement.

Sgt. Bill Parramore
Sgt. Parramore's statement concerning the days just previous to Hubb's death is essentially the same as Lt. Blacks. A memorandum from him is included in this report.
End of statement.

Recorded interviews of Lt. Black and Sgt. Paramore reveal the same information as noted in their memorandums.

The Leon County Sheriff's Office Offense Report concerning the death investigation is filed under case number 03-082193. Several Correctional Officers wrote continuations for that report. Most of those continuations primarily center on the circumstances around the finding of inmate Hubbs deceased. They note that her erratic behavior was continuing while she was in the medical infirmary. Sgt. Joyce McCary does state in her continuation that the staff physician, Dr. William Primas observed Hubbs during the day on 15 May 2003 at her request. According to Correctional Officer Dianne Brooks, he advised them to just let her continue laying on the floor. Also at the same time he was "observing" Hubbs the staff mental health worker (Natasha Carr), was present to evaluate her condition.

While confined in the medical unit Ms. Hubbs was to be checked visually hourly. These checks are recorded on a confinement log. The confinement log for 15-16 May 2003 for Ms. Hubbs is included in this report. It shows hourly checks fom 0505 hours on 15 May to 0410 hours on 16 May. However from 2105 hours until 0010 hours there are no checks recorded. Correctional Officer Clete King was the assigned medical officer during that time. In a recorded statement he advised that he relieved Officer Velveeta Davies at 2100 hours on 15 May 2003. At

approximately 2145 hours he asked Nurse Hamilton to check on the females as he checked on the males. She stated she would once she got a chance. At 2240 hours he asked her if she would accompany him to go check on the females. She stated she was too busy at the current time, but would take care of it just as soon as she got a chance. Officer King further indicates that during his training he was taught that when a male officer is assigned to the front desk it is the responsibility of the nursing staff to check on the female inmates housed in medical. At 2300 hours he was relieved by another officer. There was a violation of the Leon County Jail Standard Operating Procedures by Officer Clete King. Under SOP 6.14- Supervision Of Inmates, it requires all inmates to be visually checked hourly from 2300 hours until 0600 hours with the results recorded and maintained. However Officer King attempted to fulfill this obligation by requesting an on duty female nurse check on the inmates in the female infirmary as he is not allowed to do so without a female escort. This appears to be an inadvertent violation and would be best handled by training and PMP notations.

Detective Giordano's criminal investigation into this death revealed no foul play was involved. His interviews and information gathered also affirms that all the employees of this agency acted in a prudent manner concerning Inmates Hubb's condition. They sought medical assistance at an appropriate time and also closely monitored her condition while she was in the pod. A copy of his report in included in this file.

On 6 June 2003, I conducted a recorded interview with Sue Cole. She is the Health Services Administrator for Prison Health Services at the Leon County Jail. The purpose of this interview was to determine if the employees of the Leon County Sheriff's Office had acted in a prudent manner concerning Inmate Hubbs. Inmate Hubbs was first diagnosed with "mental problems" over a year ago. Inmate Hubbs was on several psycho-tropic drugs as well as a hormone. Inmate Hubbs was last seen by a Mental Health Services person (Natasha Carr) on 15 May 2003. Ms. Carr noted that Hubbs was seen in the infirmary due to "bizarre behavior." She displayed no verbal communication, she was lying on the floor with her pants off. She was instructed to put her pants on, she grabbed her pants but just looked at them like she was "confused." She continued to sit on the floor with no verbal communication and minimal eye contact. A further note was added to follow up in the A.M. Ms. Cole stated that when Nurse Braetcher informed her that she felt Hubbs was over medicated she contacted the psychiatrist and had her medication reduced. She cannot advise what date that was done other than sometime in May. She did state that nursing staff has the right not to administer medication without a doctor's orders if they feel the medication is causing a problem. They then contact the doctor for confirmation. Hubbs was last actually seen by the psychiatrist in April 2003. My interview with Ms. Cole did not reveal any violations of policy by correctional staff.

The autopsy performed on Inmate Hubbs on 16 May 2003 did not immediately reveal a cause of death. Toxicology results will be forthcoming.

Following is time line containing relevant information concerning this investigation:

March 20, 2002 - Ruth Hubbs is booked into the Leon County Jail on a number of charges. Her medical screening form does not note any known mental illness or infirmities.

March 28, 2002 - The medical history and physical appraisal does not reveal any claims of or signs of mental illness.

May 16, 2002 - Inmate Hubbs is referred to medical due to claimed depression and admitted prior suicide attempts. Medical refers her to the psychiatrist.

May 24, 2002 - Inmate Hubbs is seen by Dr. Chokhawala. He determines she is "drug seeking" and there is "no need for psycho-tropic drugs at this time."

Nov. 19, 2002 - Inmate Hubbs is referred to medical due to claimed depression. She indicates she has a desire "not to wake up." But denies suicidal intentions. She is referred to the psychiatrist.

Nov. 20, 2002 - Inmate Hubbs is seen by the psychiatrist, Dr. Chokhawala. She is tearful, dejected, claims to have lost 30 pounds. She states she stays in bed for 3-4 days at the time. He diagnoses her as depressed and prescribed psycho-tropic medications.

April 28, 2003 - Inmate Hubbs discovers she is facing a possibility of 10 years in prison. She begins to become more expressive of her distress over this matter.

May 1, 2003 - The pod officer notes Inmate Hubbs is slurring her words and acting "drunk." She appears disoriented and loses her train of thought.

May 4, 2003 - Inmate Hubbs fell on the floor in the middle of the pod. She still acts disoriented. She was transferred to the medical unit.

May 9, 2003 - Inmate Hubbs is returned to the pod from medical.

May 10, 2003 - Close monitoring of Inmate Hubbs is noted due to fact she appears heavily medicated. Later in date the pod officer notes she is too heavily medicated to remain in the pod. She was transferred to the medical unit again. She was returned back to the pod later that same date.

May 13, 2003 - Inmate Hubbs is observed in her room in the pod sitting on the floor. Her speech was slurred and could or would not answer questions. She appeared confused. Lt. Black and Sgt. Parramore went to medical seeking assistance. Based on medical's response the decision was made to leave her in the pod.

May 14, 2003 - Inmate Hubbs condition had not improved and in fact she had stopped eating. Lt. Black and Sgt. Parramore again went to medial. Nurse Hamilton returned to the pod with them. After observing Hubb's behavior it was her judgement she appeared over medicated. She was transported to the medical unit.

May 15, 2003 - Inmate Hubbs was visually monitored by Dr. Primus and Mental Health Worker Natasha Carr. Dr. Primus is a medical doctor and was there evaluating some abrasions on Hubb's arms.

May 16, 2003 - Inmate Hubbs is discovered deceased in her room.

FINDINGS

The Administrative Investigation of this death revealed no General Orders were violated by any employee of this agency.

ATTACHMENTS

1) Leon County Sheriff's Office Offense Report 03-082193
2) Memorandum(Liz Black)
3) Memorandum(Bill Parramore)
4) Memorandum(Clete King)
5) Pod Log
6) Medication Logs(Ruth Hubbs)
7) Progress Notes(Ruth Hubbs)
8) Confinement Log(Ruth Hubbs)
9) Cassette Tape Recorded Statement of Sue Cole
10) All other recorded statements and evidence is stored in this agency's evidence section under case number 03-082193.

PROGRAMS

Approximately seven hundred inmates participate in these programs each year!

ÿ **SUBSTANCE ABUSE EDUCATION COURSE-** This open-ended educational program meets 2 hours per week. Issues explored include addiction, relapse, recovery and treatment.

ÿ **ADULT GED CLASSES-** Sponsored by Leon County Adult and Community education, the male daytime class offers 15 - 30 hours of weekly instruction, the male evening class provides 8 hours of class time, and the female program consists of 15-30 hours weekly, depending on the needs of the students. Ten times yearly, actual GED testing occurs at the facility for those identified as academically prepared to take the battery of tests.

ÿ **JUVENILE GED CLASSES-** Provided by Lively Vo-Tech Center all juveniles attend GED classes Monday-Friday. Additionally, an ESE instructor is provided four days per week for those identified in need of special education.

ÿ **VISION OF MANHOOD** - The mission of this program is to mentor, educate and assist all male inmates in need of knowledge, support and encouragement to become more responsible men and fathers.

ÿ **LITERARY (ROTARY) PROGRAM** - Designed to break the cycle of literacy and incarceration by bonding parents and child on the importance of reading and education.

ÿ **BOOKMOBILE** - Designed to provide reading materials for inmates while incarcerated at the Leon County Jail.

ÿ **HIV (SHISTA) PREVENTION** - Provides education on HIV and STD awareness and prevention for male and female inmates.

ÿ **CHECKING PROGRAM** - Designed to educate inmates on the basic knowledge of check writing and balancing check books. Also, provides information on personal finances.

ÿ **WOMEN PARENTING** - Provides the education needed to assist female inmates in becoming responsible mothers. This is a certificate program designed to help Mother's regain custody of their children.

ÿ **ABC (ATTITUDE AND BEHAVIOR CHANGE) CLASS-** Meeting once monthly for 12 hours, this course examines the thinking and behavior patterns many inmates

demonstrate which have lead them into anti-social conduct. Lifestyle change and alternative methods of action are emphasized throughout this course.

ÿ **DAD FAMILY PROJECT-** Meeting once monthly for 12 hours, this workshop is designed for inmates who are fathers. It evolves from exploring the nature of the parenting they received to the type of parent they have been. Hands-on parenting skills are addressed as well.

ÿ **THE WOMEN'S GROUP-** This generalized support group meets for female inmates once per week for 90 minutes. Facilitated by the Refuge House, topics range from, yet are not limited to: substance abuse, release planning, and abuse victimization.

ÿ **"PATH BACK REHABILITATION"-** This class is attended by juvenile inmates housed at the facility, once weekly for two hours. It addresses a multitude of topics, including substance abuse, behavior management, life skills, and motivational techniques.

ÿ **AA AND NA MEETINGS-** Meeting once weekly, Alcoholics Anonymous and Narcotics Anonymous provides ongoing self-help meetings for those who desire support in remaining free from chemical substances, by way of approved organization volunteers.

Program	Date/Time Location	
Men Alcoholics Anonymous	Wednesday, 1930-2100 hrs	Pod K/L Classroom
Women Alcoholics Anonymous	Monday, 1900-2030 hrs	Pod M/N Classroom
Women Parenting	Monday, 1500-1630 hrs	Pod M/N Classroom
Women Narcotics Anonymous	Thursday, 1800-1730 hrs	Pod M/N Classroom
Attitude/Behavior Change (ABC)	TBA	TBA
Women's Group	Thursday, 1500-1630 hrs	Pod M/N Classroom
Visions of Manhood	Tuesdays and Thursdays, 1900-0000 hrs	Pod K/L Classroom
Dad's Program	Saturday and Sunday, 0800-1530 hrs (once a month)	Pod K/L Classroom
Substance Abuse Women	Wednesday, 1500-1630 hrs	Pod M/N Classroom
Bookmobile	1st and 3rd Fridays of the month	All Pods
Juvenile GED Program	Monday through Friday, 0830-1500 hrs	Pod G/H Classroom
Men GED Program (Day)	Monday through Friday, 0800-1500 hrs	Pod I/J Classroom
Men GED Program (Night)	Monday and Wednesday, 1800-2000 hrs	Pod I/J Classroom

Women GED Program	Monday through Friday, 0800-1500 hrs	Pod M/N Classroom
Female HIV Prevention (SHISTA)	Tuesday, 1500-1600 hrs (twice per month)	Pod M/N Classroom
Male HIV Prevention (SHISTA)	Tuesday, 1500-1600 hrs (twice per month)	Pod K/L Classroom
Female Checking Program	One Tuesday per month	Pod M/N Classroom
Male Checking Program	One Tuesday per month	Pod K/L Classroom
Literary Program	By Appointment via "Note From Prisoner"	TBA
Inmate Assistance	Case Management via "Note From Prisoner"	U.S. Mail Service
GED Tests	Once per month	Programs Office
Juvenile Path Back Rehabilitation	Two hours per week (date flexible)	Pod G/H Classroom
MEN NA	Mondays Nights @ 1900-2100	

Attachment # 6
Page 1 of 2

2004 Statistics

GED programs:

(School year runs from August of one year to May of next)

Males:
Enrolled in GED class: 77
Took GED test – 25
Past GED test - 13
Partially Past GED (3 or more parts) – **12**
Completed Workforce Development Course- 24

Females:
Enrolled in GED classes - 83
Took GED Test- 22
Past GED Test – 6
Partially Past GED (3 or more parts) – **16**
Completed Workforce Development Course- 58

Juveniles:
Enrolled in GED classes: 37
Took GED Test- 4
Past GED Test – 4
Took FCAT – 5
Past FCAT - 5
Enrolled in ESE (students with special needs) - **17**

AA Programs:

Women enrolled: 75
Men enrolled: 78

NA Programs:
Women enrolled:75
Men enrolled: 85

Female Substance Abuse:
Women Enrolled: 45

Vision of Manhood:
Men Enrolled: 45

DAD's Classes:
Men Enrolled: 120

ABC class for men:
(Class ran from January – June 04)
Men Enrolled: 60

Womens Group:
Female Enrolled: 45

DRUGS, INCARCERATION AND NEIGHBORHOOD LIFE: THE IMPACT OF REINTEGRATING OFFENDERS INTO THE COMMUNITY

EXECUTIVE SUMMARY

By

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1992; Mauer, 2000), up to 13% of adult males enter prison or jail in a given year (CASES, 2000) and up to 2% of all residents enter prison in a given year (Rose, Clear, Waring and Scully, 2000).

Recently, Rose and Clear (1998) theorized about the implications of this concentration of incarceration on community life. They built upon Bursik and Grasmick's (1993) reconceptualization of social disorganization theory which merged social disorganization and systemic theories to specify how the three levels of social control (private, parochial and public) mediate between deleterious environmental characteristics and crime. Rose and Clear (1998) theorized that the aggregate impact of incarceration damages networks of private and parochial social control by disrupting the social networks at their foundation. Thus, in this theoretical model, when public control occurs at high levels, private and parochial controls function less effectively. The result is higher levels of community disorganization and more crime. An empirical test of their theory (Rose, Clear, Waring and Scully, 2000) finds support for the proposition that high concentrations of incarceration increase, rather than decrease, crime.

This idea of incarceration as a form of "coercive mobility" (Rose, Clear, Waring and Scully, 2000) has considerable theoretical salience for contemporary criminology because it updates one of social disorganization theory's main constructs (residential mobility) to account for the new significance of incarceration. It also enhances our understanding of "collective efficacy" (Sampson, Raudenbush and Earls,1997; Sampson and Raudenbush, 1999), the actualized action produced by social capital, since "coercive mobility" would destabilize the social networks necessary for local residents to positively affect community-level social control. Thus, "coercive mobility" might be seen as a mechanism that tends to damage social capital (Coleman, 1990) the resource on which neighborhoods rely for the quality of collective life. In

sum, the theory of "coercive mobility" argues that the aggregate impact of incarceration may have unintended consequences. This is because, at the neighborhood-level, this form of public control constrains the effectiveness of private and parochial control (Hunter 1985), thereby reducing the community's collective efficacy and, in the end, fostering the conditions that lead to more disorganization and more crime.

THE CURRENT STUDY: DATA AND METHODS

The purpose of this study was to investigate the aggregate impact of incarceration on the quality of community life in areas experiencing high concentrations of incarceration. Specifically, we were interested in finding out how residents perceive incarceration impacting them, their families and their community overall. We were particularly interested in identifying problems associated with the process of removing and returning offenders, rather than the experience of incarceration itself, because we wanted to focus on how incarceration affects the networks of association which are the basis of informal social control. Thus, our approach was designed to identify factors associated with incarceration which either promote or reduce community stability and as a result, either promote or reduce crime.

To accomplish, we conducted a study of two Tallahassee, Florida, neighborhoods which had been identified earlier (Rose, Clear, Waring and Scully, 2000) as having high rates of incarceration relative to other locations in that city. We reviewed archival and contemporary documents about the development of these two neighborhoods and, employing a snowball approach, we interviewed over 30 local officials, community leaders and social service providers to understand the contemporary social and political context of these locations. These individuals

were also instrumental in providing initial referrals to residents. After pilot tests, we then conducted individual interviews and a series of four focus groups (attended by a total of 25 residents and 9 ex-offenders) with people either living or working in those areas. All interviews were transcribed and subjected to content analysis to explore major themes in the data (Lofland and Lofland, 1995).

We did not ask respondents directly about the impact of incarceration on social networks or public safety. Instead, our approach was to ask for general commentary about the impact of incarceration on themselves, their families and their communities, and then to explore the responses we received to these opening probes. The focus groups, led by a professional group facilitator, were conducted at various sites in the neighborhoods, and were hosted by a representative of the local neighborhood association. The facilitator was assisted by members of a local justice advocacy organization, one of whom had previously been incarcerated. Ex-offenders were interviewed separately from neighborhood residents to maximize everyone's comfort in talking about sensitive issues of incarceration and re-entry.

RESULTS: FOUR DOMAINS OF COMMUNITY IMPACTS

It is important to emphasize that respondents report a complicated picture of the effects of incarceration on their neighborhood. Some of the consequences they describe are "positive," in the sense that the neighborhood and its residents want their communities to be safer and sometimes they are better off when some residents are incarcerated. Not surprisingly, residents feel that justice is done when wrongdoers are apprehended, prosecuted, and sanctioned since they create problems for the quality of life of those who are law-abiding. Our respondents did

not hesitate to say that removing committed offenders makes the streets safer and their lives better.

At the same time, our respondents expressed opinions that show the negative effects of incarceration too. In our focus groups and interviews, respondents devoted more time to describing the negative impact of incarceration on their communities than they gave to the positive, and their passions seemed to be more readily engaged by these issues than the traditional matters of public safety. Ex-offenders raised the same kinds of themes as their neighbors, but also emphasized the heavy pressure they feel, from almost every source: the criminal justice system, everyday society, their neighbors, and their families.

Our analysis suggests four domains that capture the impact of incarceration on the individuals, families and the community-at-large: the problem of stigma, financial effects, issues regarding identity, and the maintenance of interpersonal relationships.

Incarceration and the Problem of Stigma

Being involved in the criminal justice system carries a negative social status. Neighborhoods that contain disproportionate numbers of incarcerated residents suffer from stigma in several ways. First and foremost, the status of "Offender" becomes an individual's master status and shapes the way others view him and the opportunities which come his way. Within the community the experience of incarceration is widespread yet stigmatizing among local residents. One sign of this is that incarceration is not discussed openly, even when neighbors know a nearby resident has been incarcerated. Sometimes, the stigma transfers to family and community. Families report feeling others sometimes look at them differently when

one of their own has been incarcerated. Finally, there is a loss of the community's reputation as a good place to live and/or do business when it becomes known as a place where many residents are, or have been, incarcerated.

The Financial Impact of Incarceration

One of the most significant points our respondents repeatedly make is that incarceration has adverse effects on the financial capacity of the neighborhood. Sometimes families experience financial relief when someone who has been a financial drain is incarcerated. More often, however, respondents report that families struggle to compensate from the financial loss of a breadwinner (regardless of whether the income came from legal or illegal sources). During incarceration, families frequently support the offender with spending money for food and other necessities and experience a financial drain by accepting collect phone calls and taking time off from work to visit. After incarceration, the family often continues to support the ex-offender upon his return to the community by providing both financial support and a place to live. Since ex-offenders find it very difficult to find employment at all, and when they do, often it provides a meager income, family support may continue for years. Finally, the communities experience financial loss when ex-offenders fail as employees in local businesses and when local businesses lose customers from idle residents congregating on the street.

Incarceration and the Problem of Identity

The residents and ex-offenders who live in communities that have high concentrations of residents flowing in and out of prison know they live in "problem" places. Thus, incarceration

can influence identity both directly and indirectly. In particular, respondents report that residents and ex-offenders often experience a loss of self-worth and self-esteem. At the same time, ex-offenders have such a difficult time making a successful re-entry into the community, they fail to become positive roles modes. Part of this difficulty comes from the trouble ex-offenders have convincing others of their changed identity. Overall, the pervasive experience of incarceration results in community residents experiencing a sense of hopelessness and apathy.

Incarceration and the Dynamics of Community Relationships

Interpersonal networks are affected in multiple ways. At the minimum, when someone is incarcerated, spousal and parent-child relationships become strained or severed. Sometimes this means that the supervision of children suffers. The aggregate effect of these disruptions reduces the capacity of social supports for all concerned. Alternatively, sometimes removing a problem family member can improve relationships among remaining family members. Relationships in the community also are impacted. For instance, sometimes families isolate themselves from the community due to shame and real or perceived stigma. Thus, relations with neighbors can become strained. Relationships to neighbors for residents and ex-offenders often becomes strained when ex-offenders return from prison because neighbors are cautious, suspicious and fearful of ex-offenders at the same time that they welcome them home. Sometimes families or ex-offenders relocate to a different neighborhood to increase the chances of the ex-offender's successful reintegration. This may mean moving in with extended family members (which disburses the financial burden even wider) or losing support networks left behind in the old

community. Finally, interaction in the neighborhood becomes restricted as people reduce their public social interaction due to police surveillance.

DISCUSSION

These four domains of impact reflect immediate problems for communities experiencing high rates of incarceration and also have implications for long-term community stability. The human capital of offenders is impacted directly through incarceration in both positive and negative ways. For instance, ex-offenders tell about using incarceration as a time to change their lives by getting an education, getting off drugs and developing skills they would need for a successful transition into the community. On the other hand, incarceration reduces their human capital by failing to provide adequate counseling, schooling and training, (sometimes even training them in obsolete and outdated skills). When they are released, most offenders find it very difficult to find employment; those who do have unstable jobs earning meager wages. This study also revealed ways in which incarceration reduces human capital of non-offending residents. Single parents (usually mothers) in the community become more stressed and burdened, and they have more difficulty getting and keeping jobs. Children sometimes go hungry, attend school sporadically, are disciplined less frequently and sometimes engage in crime. For these children, the result is attenuated skills and diminished life chances.

Social capital in the community is also effected by incarceration because it is a mechanism which alters the networks of association which are the foundation of this important resource. Networks can be improved when removing a disruptive family member gives other family members a chance to heal and repair their relationships and "good" children who may

have been overlooked while their disruptive siblings lived at home may receive more attention when the sibling is removed from the family. Alternatively, networks are disrupted when families feel bad about their loss, often experiencing illness and depression, when relationships with extended kin become taxed, and spousal relationships are disrupted. Networks suffer further when neighbors isolate from each other because families withdraw from community life, or when neighbors become suspicious and/or fearful of those returning from prison. And finally, networks fail to form when the community becomes isolated from the larger society. Thus, while these issues surrounding incarceration are problematic on their own, they also are problematic because of how they influence the ability of community residents to form, sustain and build networks both within the neighborhood and between the community and the larger society.

Anger frequently was mentioned as an outcome of incarceration. Many times respondents were referring to feelings children experience when they "lose" a parent through incarceration but often they were referring to feelings they had at a system which they saw as unjust. In some ways, the most complex and yet most combustible issue arising from our study is the sense of oppression expressed by our respondents. The people in our interviews know that African-Americans are disproportionately involved in the prison system and that their neighborhoods lose residents to the prison system at rates higher than elsewhere. They also feel that government officialsdo not respond to the problems of jobs, income, housing, and childcare that concentrate in their neighborhoods with the same degree of urgency as in locations just a short distance away. In explaining these differences, they recognize the personal failings of the

men and women who end up in prison. But they also describe systems of inequality and injustice that establish the foundation for these concentrations of criminal justice activity.

Racism is a subtle theme, but an inescapable one. Some of our respondents are more comfortable raising it than others (we can only speculate about the effects of having a white research team doing the interviewing) but nobody disputed it when the topic came up. The people who live in the neighborhoods of our study are confident that injustice plays a role in the workings of the criminal justice system, and that the problems of their neighborhood are made more difficult by a larger societal pattern of injustice.

The criminal justice system does little to soften this feeling. Intent on preserving public safety, police focus their attention on newly released offenders, to the point where these men commonly feel under a form of civic harassment. Police cars, cruising around the neighborhood, seem in constant tension with young people. Although many of our respondents want to reduce crime and see this as occurring through more arrests and more enforcement, they also are asking for a scaling down of the police presence because they see the harm this does, too. Thus, another way incarceration impacts the quality of community life is by exacerbating and concentrating residents' feelings of oppression and further increasing their alienation from mainstream society.

The subsequent loss of legitimacy of the criminal justice system (LaFree, 1998) decreases both the incentive for law-abiding behavior and for residents to report crime that they see. This creates an "us" versus "them" mentality where residents want crime to lessen in their communities but where they are unwilling to collaborate with the police to accomplish it. This was, perhaps, the biggest contradiction expressed by our respondents. They clearly see crime as

a problem in their neighborhoods and want their areas to be safer. They simultaneously believe the police are harassing them unnecessarily and that the police could do more to eradicate crime if if that was their intent.

Incarceration, Social Capital, and Drugs

This sentiment was particularly true with regard to drugs. For many of our participants, concern about public safety is linked closely to the problem of drugs. Often, this discussion makes a connection between disorder, criminal justice, and crime. Many of our respondents call for more criminal justice activity and more stringent criminal justice responses. Participants often indicated that tougher responses to crime would make the streets safer. This kind of concern is expressed more in relation to drug dealers than to other drug offenders. The former are seen in particularly harsh terms. Residents see the dealers as very destructive, damaging lives and taking over the streets. They see strong criminal justice measures as justified in relation to dealers.

Drugs, then, are the backdrop to this study. As a problem on their own they were hardly ever mentioned. True, many ex-offenders discussed their personal problems with drug addiction and described how this posed additional challenges for them upon their return to the community. It also is true that when discussing crime, community residents quickly brought up drug dealers and the problems they contribute to crime. But when we centered the conversation on incarceration and reintegrating ex-offenders into the community residents never mentioned drugs as an issue. We believe this is because they thought of drug dealers exclusively as outsiders and drug use was not problematic for the community. In fact, there was a tendency for residents to

be understanding about individuals and the crimes they commit, saying "it depends on the crime" and classifying many as not serious or comprehensible in the face of widespread unemployment and systemic discrimination. At the same time, however, they expressed concern about their own potential victimization when ex-offenders returned to the community.

RECOMMENDATIONS

It is clear that some offenders need to be incarcerated and this report does not recommend that incarceration be abandoned. Not only would that be unreasonable and impractical but to make such a recommendation would fail to recognize the positive aspects of incarceration. Clearly the community benefits when some people are removed. We note, however, that current policy initiatives that increase reliance upon incarceration have the effect of exacerbating the problems we have identified. The prudence of these policies must be considered in light of the way they affect neighborhood life in certain areas.

Our recommendations are designed to offset the effects of concentrated incarceration as induced by current policies. An alternative approach would be to call for a more selective use of incarceration and a wider array of sanctioning strategies that would do less damage to family relationships and the social networks in the communities. Although none of our participants called for an end to the use of imprisonment, many felt the need for a more restrictive use of prison sentences.

We take no position on this question, though we recognize the importance of the debate. Instead, implementation of our recommendations would offset the negative, unintended consequences of incarceration as it is now used, making it a more effective tool for social

control. The recommendations are not focused on the conditions of imprisonment. Rather, they focus on the kinds of services and programs that might improve the quality of life in the community. We recognize that the recommendations are not a panacea for the problems in the neighborhood studied, nor can they offset, in the short term, years of concentrated incarceration. Taken as a whole, however, we believe these recommendations would increase community safety by shoring up both residents and ex-offenders in the community. In doing so, human and social capital can be increased and the networks of association needed for informal social control can be revitalized.

Below we outline sixteen recommendations that emerged from our research in the two communities of Frenchtown and South City. We recognize that one of the limitations of the case study and focus group approach is that our findings might not be generalizable to other communities. We believe, however, that the issues raised by our participants are relevant to other high incarceration neighborhoods, even if the exact form of the service or program might have to be adapted to particular local areas. A general theory of new program initiatives in high incarceration communities would have informal social controls as a target for change, because these are the community supports that are disrupted by high rates of incarceration. In order to strengthen the capacity of informal social control, we recommend programs or strategies that ease financial burdens, ameliorate the costs of stigma, build pro-social identity, and strengthen family and community relations. In the realm of public safety theory, this would mean that we are in search of programs that promote "collective efficacy."

Finally, although the criminal justice system suffers from a credibility deficit in these neighborhoods, our participants see a role for the criminal justice system in dealing with the

problems they raised. One reason is that they see public safety as a significant problem where they live, and the common expectation is that criminal justice is supposed to provide public safety. Thus, our recommendations pertaining to the criminal justice system are inclusive and call for a role for criminal justice, not merely a series of new social programs.

The question is, how can we carve out a stronger role for criminal justice and related agencies that has as its target the invigoration of informal social control and collective efficacy? In our analysis, the actions of criminal justice are a part of the problem; how can they be revamped to become a part of the solution? We address these question by presenting a comprehensive strategy for high incarceration neighborhoods, one that targets these locations rather than applies across whole jurisdictions.

Recommendation 1

Target families of incarcerated offenders for an array of services. Appropriate services will alleviate many of the problems and the level of disorganization incurred immediately by many families when a member is incarcerated. These services might include:

a. Short-term financial assistance for food, clothing and housing.

b. Short-term, crisis-oriented, mental health assistance to deal with anger, depression, and self-esteem issues, particularly for children.

c. Parenting classes.

d. Dental and physical health assistance.

e. Supervisory and recreational services for children.

f. Adult mentors for children.

Recommendation 2

Facilitate contact between families and incarcerated family member. Assistance would promote the family bonds that are essential for successful reintegration into community life, and it also would help individuals maintain their ties with their children while incarcerated. Maintenance of family bonds, especially with children, often is an incentive for an inmate's "good behavior" while incarcerated. Assistance might include:

a. Low-cost telephone service between inmates and their families.

b. Assistance with transportation to prisons.

Recommendation 3

Provide services to children of prisoners to help stabilize their living situation. Many children lose one or more of their parents to incarceration, and many are raised by a caretaker relative – grandmother, aunt, or sister, for example, or are placed in foster care. These children, and their caretakers could benefit from the following services:

a. Counseling for common problems, such as depression, anger, shame, and low self-esteem.

b. Counseling for caretakers about how to talk with the children about the situation.

c. Intervention regarding acting-out problems.

d. Assistance in maintaining meaningful contact with the incarcerated parent, including family-oriented programs in prison.

Recommendation 4

Implement comprehensive pre-release transition plans that address family needs. These plans would maximize the health of the family, optimize successful re-entry, and reduce recidivism by anticipating the problems incurred when an ex-offender is released. Transition plans might:

a. Determine whether inmates should return to their families upon release.

b. Determine whether released individuals should return to their communities or move to new neighborhoods.

c. Determine whether families and released ex-offenders should move to new neighborhoods together.

d. Identify employment and housing possibilities for families and returning offenders who choose to move to new neighborhoods.

e. Link inmates to the exact services they need upon release, and begin the service delivery process prior to release.

f. Address typical inmate fears, such as concern about partner faithfulness, community attitudes, etc.

g. Provide family-focused interventions to cope with the strain of reintroducing the ex-offender into the family.

Recommendation 5

Provide transitional housing for ex-offenders. This would alleviate the immediate need ex-offenders have for a place to stay and prevent people from heading to the streets or the shelters. It also would relieve the burden families sometimes experience when they house ex-offenders.

Such housing, with a house monitor to assist ex-offenders in reintegrating, could function as a service center, facilitating the process of obtaining identification papers, clothing, employment, etc.

Recommendation 6

Modify low-income rules that disallow individuals with a felony record to acquire a lease. The inability of many ex-offenders to acquire a lease often forces them into transient living conditions and, in effect, undermines their acceptance of responsibility. It also can rupture marital and parental relationships, when, for example a man's wife is allowed a lease but must "sneak" him in to visit. Such an arrangement is also detrimental to the ex-offender's self-esteem and presents a poor model of fatherhood to children.

Recommendation 7

Assist ex-offenders in obtaining and retaining employment. Such assistance would alleviate the financial strain ex-offenders experience and the financial burden often absorbed by families, and it would also reduce the stigma associated with incarceration and unemployment. Assistance might include:

a. Programs to help ex-offenders become self-employed.

b. Employer education programs to promote the hiring of ex-offenders.

c. Encouraging employers to hire ex-offenders through a program of government "bonding" to reduce the risk assumed by potential employers.

d. Encouraging employers to provide full-time employment (40 hours per week) and benefits.

Recommendation 8

Make training, education, and legal assistance available to ex-offenders. Training and education are the foundation of quality employment. Ex-offenders who have trouble getting good jobs should be able to obtain job training. In addition, ex-offenders need basic information about legal issues and need assistance in solving legal problems. Ex-offenders also need help in restoring their civil rights and closing out any pending criminal cases and legal obligations. Affordable legal help is not typically available and thus, internships for students from the local law schools could be instituted to assist with the legal needs of ex-offenders and their families.

Recommendation 9

Reduce the initial financial pressures faced by ex-offenders immediately upon release. This can be accomplished by reducing the unnecessary burdens imposed by the criminal justice system, such as supervision fees, and providing short-term financial assistance to pay for such needs as security deposits and the first month's rent, initiating utilities, and obtaining toiletries and other basic necessities. Such financial assistance would reduce the incentive to participate in illegal activities for quick money.

Recommendation 10

Increase the availability of low-cost drug treatment programs for ex-offenders & families. Currently available programming is insufficient to meet needs or, because it is not locally based, is not easily accessible to residents of these neighborhoods.

Recommendation 11

Form self-help support groups for ex-offenders. These groups would help model successful reintegration into the community where ex-offenders can talk to each other about the pressures and temptations they face, the frustrations of trying to make it, the discouragements of everyday life. They can also help head off relapse and recidivism by reducing anger and bolstering self-esteem.

Recommendation 12

Match ex-offenders to community mentors. Mentors would serve as advisors, contacts and support for returning offenders. They can help ex-offenders with very basic life skills, such as how to open a checking account and other mundane requirements. Mentors can also be part of the transition planning process and serve as advocates for the ex-offenders' needs and interests in re-entry. The mentor system can apply to families, as well, with families "adopting" other families for support.

Recommendation 13

Involve ex-offenders in neighborhood projects. Ex-offenders can play a role in a wide range of positive neighborhood activities, from organized sports programs to neighborhood reclamation projects. This would put ex-offenders in productive contact with fellow residents in neighborhood activities that lead to the overall improvement of the community. It also would reduce stigma and isolation associated with incarceration. These projects might include:

a. Work programs that improve public space in the community.

b. Renovations of housing and other building stock.

c. Recreational sports programs.

Recommendation 14

Develop awareness programs to reduce the stigma of incarceration for ex-offenders. De-stigmatizing individuals and communities should help reduce the pressures experienced by ex-offenders who are attempting to make a new start in the community. A broader understanding of the needs and obstacles facing ex-offenders will also enhance the quality of community life by countering some of the unintended consequences of incarceration. Programs might target:

a. Police, to help alleviate difficult community tensions.

b. Probation officers, to assist in the reintegration process.

c. Employers, who may disdain or are fearful of hiring ex-offenders.

d. Educators, who can talk about the problem of re-entry with greater sensitivity.

e. The community-at-large, to encourage tolerance for returning felons.

Recommendation 15

Provide services at a neighborhood-based center. A neighborhood-based center would:

a. Promote access to services for families and returning offenders.

b. Enable services to be tailored to the specific needs of the community.

c. Promote integration and informal networks by locating multiple services in one place.

d. Involve neighborhood groups, such as the neighborhood associations, in the design and delivery of services.

e. Transfer resources from society-at-large to the community by adding a local service entity to the neighborhood and by being a site through which financial resources can be funneled into the neighborhood.

Recommendation 16

Provide services through coalitions and partnerships of public and private sources. Human service organizations, both public and private non-profit, can organize coalitions to develop and concentrate their work in high incarceration communities. Private, for-profit organizations can contribute to the costs of public services, financially and programmatically. This would leverage the resources of both public and private interests and direct them toward community-based strategies, which might include:

a. Police partnerships with resident groups to engage in problem-solving strategies and to provide families with support when they need it.

b. Social service provider-neighborhood partnerships to coordinate and intensify local service delivery.

c. Public-private partnerships to create new jobs for residents.

d. Expert-citizen group partnerships that help resident groups develop grant proposals and new projects.

CONCLUSION

The perspectives of residents and ex-offenders can be seen as a call for change in the way justice services are provided in high impact communities. We can envision a comprehensive programmatic response to the problems that arise from high rates of incarceration concentrated in certain communities. While many of these services and programs can be provided by private or non-criminal justice agencies we think the criminal justice system is ideally situated to provide umbrella services for these families. It has direct knowledge of any families who are affected by someone's arrest and conviction, and the kinds of services families need are not dramatically different from the kinds of services required by victims of crime, a service area in which the criminal justice system has been improving for the last decade or so.

Many of the problems we discuss in this report are experienced by people associated with incarceration but who live in areas with a lower concentration of residents going to prison, than that in Frenchtown or South City. As a result, their problems are isolated, less characterized by their neighborhood, and they generally have more resources with which to face and fight their problems. By contrast, neighborhoods with high incarceration face several additional obstacles, making it more difficult for residents to cope with the problems associated with incarceration. For instance, most high-incarceration neighborhoods are poor, multi-problem areas; their residents have low levels of education and suffer high rates of unemployment. Children are raised in single-parent households, public housing is commonplace, and rental property dominates. There is a lack of many formal business, so that employment requires mobility outside of the neighborhood. Of household heads who work, many take more than one job at minimum wage, some work "off the books," and day labor is common. Schools are often

inadequate, with behavior problems, truancy, and poor academic achievement. These are the common problems afflicting the neighborhoods of "the underclass" (Wilson, 1987) and they come in mutually-reinforcing, interwoven systems of forces rather than as isolated deficiencies.

Socially disorganized areas (such as those with high incarceration rates) also tend to suffer from limited parochial social controls (Rose, 2000). Neighbors do not know one another well, nor do they interact with one another in consistent ways. There are few social clubs or organized community activities. All of the benefits that accrue from strong neighborhoods are noticeably absent from these places. The main external force operating in these places is the criminal justice system. It is in these places that police typically set up neighborhood offices when they practice community-oriented policing. Studies of these locations (CASES, 2000) show that millions can be spent in justice services, with dozens of citizens under formal justice surveillance, even in very small segments of larger neighborhood areas. In the absence of informal social controls, formal versions of externally-managed control systems dominate.

A strategy to counteract these problems must have three characteristics. It must be comprehensive, addressing the multiple levels of problems rather than one or two at a time. It must seek to add stability through strengthening social networks, rather than targeting specific individuals. And it must transform people and circumstances from their extant problem situations toward new pro-social equilibria. These strategies would be "building" strategies that add value to the community, rather than subtracting value. Our recommendations take this approach.

It is important to emphasize that not all offenders will "want to change;" that is, some offenders will earnestly resume their old lives upon re-entry. Likewise, not all families will be well-suited to receive ex-felons supportively upon their re-entry. We recognize that there are

public safety issues facing the criminal justice system that call for supervision, surveillance, and enforcement, and do not wish to undermine that fact. Our recommendations are meant for the case in which an offender wants to succeed but faces significant obstacles in doing so, and the offender's family wants to be a support system but lacks the capacity for doing so as fully as might be possible with services. This applies to many, if not most, of the situations involving re-entry to high incarceration neighborhoods. While we see these recommendations as particularly useful to the neighborhoods of Frenchtown and South City, we think they potentially would be useful to high incarceration locations, generally.

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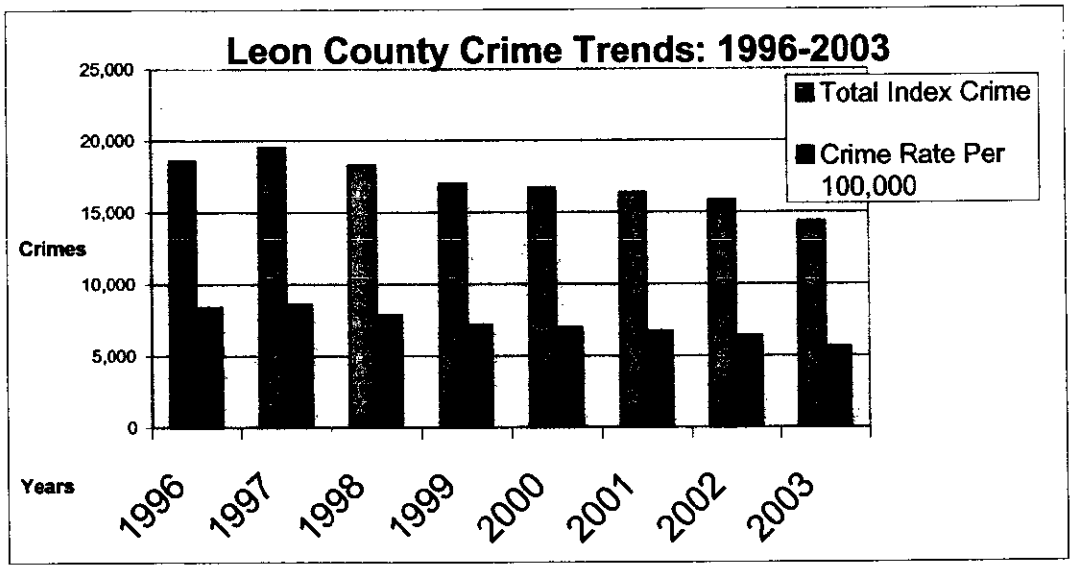
Leon County Crime Trends: 1996-2003

Source: FDLE Crime Trends

Year	Population	% Change in Population	Total Index Crime	% Total Index Crime Change*	Murder	Forcible Rape	Robbery	Aggravated Assault	Burglary	Larceny	Motor Vehicle Theft	Crime Rate Per 100,000	% Crime Rate Change Per 100,000*	% Cleared
1996	221,621	1.9%	18,559	-11.7%	15	148	473	1,576	3,276	12,024	1,047	8,374.21	-13.3%	25.36
1997	227,714	2.7%	19,527	5.2%	7	173	641	1,979	3,093	12,503	1,131	8,575.23	2.4%	27.18
1998	233,232	2.4%	18,265	-6.5%	7	140	601	1,739	3,477	11,255	1,046	7,831.26	-8.7%	26.61
1999	237,637	1.9%	16,967	-7.1%	5	194	566	1,862	3,234	9,799	1,307	7,139.88	-8.8%	33.24
2000	239,452	0.8%	16,684	-1.7%	9	147	525	1,844	3,581	9,563	1,015	6,967.58	-2.4%	34.5
2001	244,208	2.0%	16,347	-2.0%	7	177	543	1,730	3,492	9,257	1,141	6,693.88	-3.9%	31.2
2002	248,039	1.6%	15,781	-3.5%	9	202	464	1,424	3,391	9,252	1,039	6,362.31	-5.0%	27.5
2003	255,500	3.0%	14,328	-9.2%	8	193	404	1,277	3,138	8,381	927	5,607.83	-11.9%	26.9

* Percent changes in number and rate should be interpreted with caution. In small jurisdictions with low numbers of crime, a small increase in crime can produce a large percent change. In addition, increases or decreases of 100% my be due to agencies not reporting for the year or previous year or reporting "zero" crimes. When using number or rate changes, it is best to consider the number of crimes actually reported for the year and for the previous year.

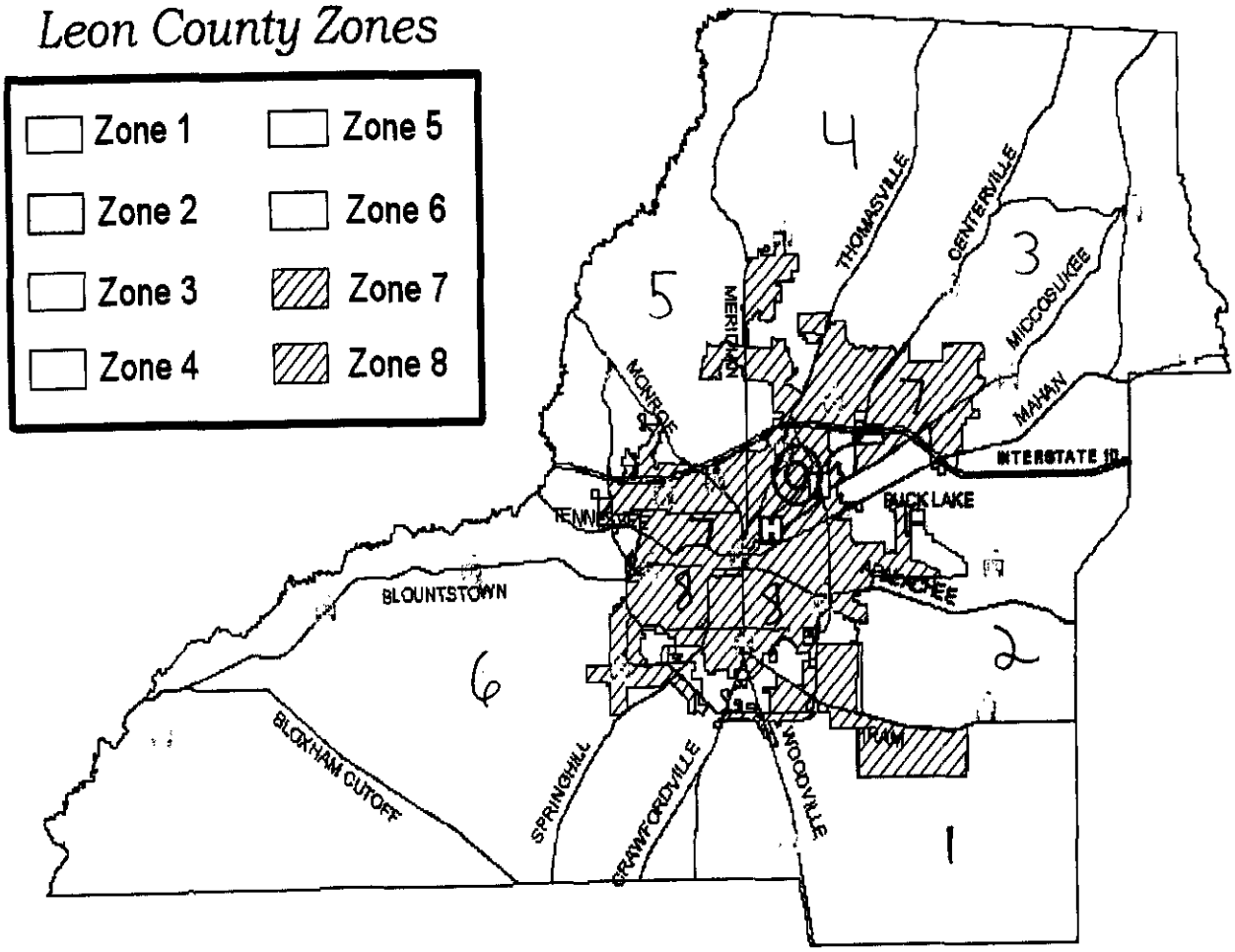


Attachment #
Page ___ of ___

Attachment # 9
Page 1 of 1

Leon County Sheriff's Office

Arresting Charges by Zone
Calendar Year 2004

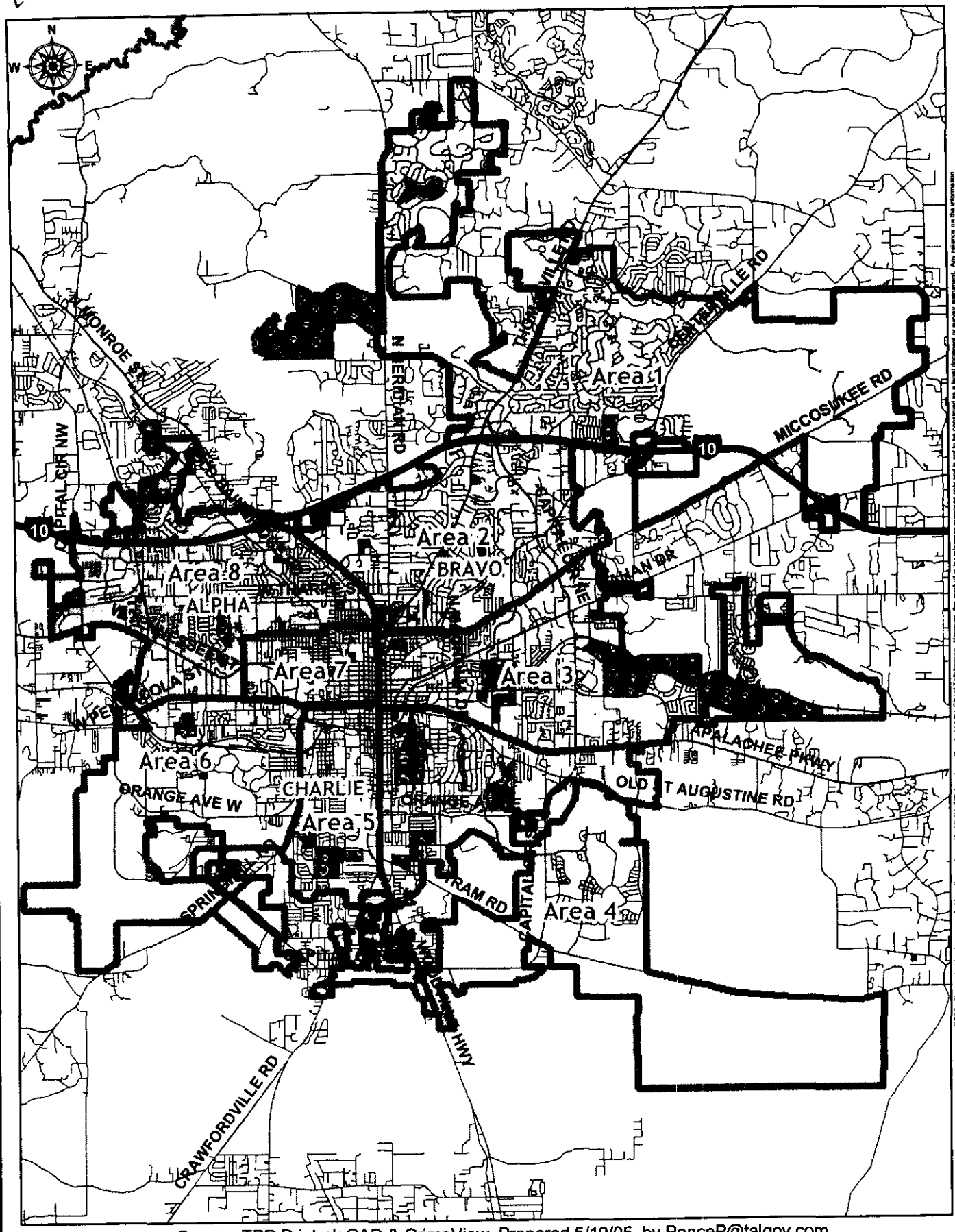


	Zone 1	Zone 2	Zone 3	Zone 4	Zone 5	Zone 6	Zone 7	Zone 8	Totals
Adult	615	167	115	200	516	513	861	966	3,953
Juvenile	67	61	16	51	37	50	167	220	669
Total	**682**	**228**	**131**	**251**	**553**	**563**	**1,028**	**1,186**	**4,622**

Attachment # 10

Page 1 of 2

TPD Districts and Areas



Source: TPD Printrak CAD & CrimeView, Prepared 5/19/05, by PenceP@talgov.com.

Tallahassee Police Department

Arrests by Patrol Area

2004

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Total
Arrests	122	531	874	954	774	917	1,663	1,023	6,858

Attachment # 10
Page 2 of 2

TALLAHASSEE POLICE DEPARTMENT
GENERAL ORDERS MANUAL

Proudly Policing Since 1841	SUBJECT: Arrests CHIEF OF POLICE		Nationally Accredited 1986
NUMBER: 6	ISSUE DATE: 11/15/2001	EFFECTIVE DATE: 11/15/2001	TOTAL PAGES: 1 of 8

AUTHORITY/RELATED REFERENCES

Section 790.052, Florida State Statutes, Concealed firearms/off-duty officers
Chapter 901, Florida State Statutes, Arrests
General Order 59, Transporting and Booking Procedures
General Order 64, Vehicle Impounding
General Order 71, Juvenile Civil Citation Program
Vienna Convention on Consular Relations
Diplomatic/Consular Immunity: Guidance for Law Enforcement

ACCREDITATION REFERENCES

CALEA Chapter 1, 71, 74

KEY WORD INDEX

Arrests with a warrant: Procedure VI
Arrests without a warrant: Procedure V
Decisions to arrest or not arrest: Procedures II and III
Foreign Nationals Arrested: Procedure VIII
General guidelines: Procedure I
Obtaining an arrest warrant: Procedure VII
Off-duty officer arrest authority: Procedure IV

POLICY

Officers of the Tallahassee Police Department shall use reasonable judgment and appropriate discretion when making decisions that may lead to an arrest. Officers shall abide by the United States Constitution, the Florida State Statutes, and other applicable legal guidelines in all arrest situations.

DEFINITIONS

Foreign National: (For purposes of consular notification) Any person who is not a citizen of the United States, including "aliens" who possess a United States "Green Card" and those illegally in the United States. A foreign national claiming the United States as one country in their dual citizenship shall be treated exclusively as a citizen of the United States.

On-duty police officers: Officers working their regular duty assignment or any special assignment compensated by the Department.

Off-duty police officers: Officers not engaged in on-duty or secondary employment activity.

Secondary employment: Employment where officers work for an entity other than the Department where a condition of the employment is the actual or potential use of law enforcement powers by the employed police officer.

PROCEDURES

I. GENERAL GUIDELINES

A. When effecting arrests, officers shall ensure those rights mandated by the United States Constitution are provided to the arrested person.

B. When effecting arrests, officers shall obey the laws of arrest as outlined in Chapter 901, Florida State Statutes.

C. All arrested persons shall be handcuffed (hands behind back) unless circumstances reasonably justify otherwise. If reasonably necessary, additional or other restraint devices may be employed for the safety of the arrested person and the officer (see General Order 59, Transporting and Booking Procedures).

D. When arresting any person who appears to be inebriated, intoxicated, or not in control of his or her physical functions, officers shall examine the arrested person to ascertain whether or not the person is in possession of medic-alert identification (bracelet, necklace, etc.) specifically delineating a medical disability that would account for the actions of the arrested person. If such identification is found, officers shall take immediate steps to ensure the arrested person receives appropriate medical attention for the disability.

E. Officers are responsible for the safety and protection of arrested persons while in the custody of the Tallahassee Police Department, and shall ensure arrested persons are:

- Not left unattended.
- Provided appropriate medical care for any injury sustained during the arrest.

F. Officers are responsible for any personal property in possession of, or under the control of, a suspect at the time of the arrest. Officers shall ensure the property is either turned over to an authorized person of the arrested person's choice, properly impounded, or properly submitted to another agency. Refer to General Order 64, Vehicle Impounding, for more information on the disposition of an arrested person's vehicle.

II. DECISION TO ARREST

A. If a violation of law or ordinance has occurred, it is the responsibility of on-duty police officers and officers working secondary employment, using reasonable judgment and appropriate discretion, to take all steps necessary to affect an arrest of the suspect(s). Officers shall use appropriate officer safety tactics in every arrest incident.

B. Officers shall not make arrests outside their jurisdiction, except in:

- Fresh pursuit of a suspect for a violation occurring inside their jurisdiction.
- Mutual Aid situations.

C. Officers should not consider the following in any arrest situation:

- The victim's willingness to pursue criminal charges in court.
- The possibility that the suspect may not be prosecuted.

III. DECISION TO NOT ARREST

A. There may be situations where probable cause exists for the arrest of a suspect, but circumstances might cause officers to not effect an arrest. Some of these circumstances include:

- When the arrest would cause a greater risk of harm to the general public than not arresting the suspect (e.g., the suspect in a minor offense takes refuge in a large, volatile crowd).
- When police resources are limited and there are a large volume of high priority calls for service (e.g., arrests for minor offenses where the City or State is the victim during an extremely busy shift would take too much valuable officer time).

- When referral to a recognized diversion program seems a more appropriate and reasonable course of action (e.g., Juvenile Civil Citation Program, Neighborhood Justice Center).

B. Even if an arrest is not made at the time of the crime, officers may obtain arrest warrants for suspects which they have probable cause to believe committed a crime.

C. When officers do not effect an arrest in an incident, they shall still complete an offense report if anyone involved in the incident could subsequently:

- Claim to be physically injured.
- Claim to have suffered a property loss.
- Seek to pursue criminal charges against another person involved in the incident.

D. If officers have questions or doubts about effecting, or not effecting, an arrest, they should seek the counsel of a supervisor (if supervisors have questions, they should seek the counsel of the Department's Legal Advisor).

IV. OFF-DUTY OFFICER ARREST AUTHORITY

A. While off-duty, officers shall not effect arrests:

1. In their own quarrels, in those of their families or friends, or in disputes arising between their neighbors except in circumstances where officers reasonably believe:

   - They are justified in using force to prevent injury or death to another person.
   - They are justified in using force in self-defense.
   - A serious crime has been committed.

2. For non-threatening crimes except when the violations are willful and repeated.

3. For traffic violations except when officers reasonably believe that an arrest must be made to prevent injury to themselves or another person.

4. Outside their on-duty jurisdiction (See Procedure II B above).

5. When they are under the influence of alcohol or taking medication, which impairs their judgment.

B. To avoid confusion to suspects, citizens, and responding on-duty officers, off-duty officers who are authorized to effect an arrest shall do so only when in possession of appropriate City of Tallahassee/Police Department identification, to include, but not limited to:

- Police identification card with photograph.
- City issued or authorized police badge.

C. Off-duty officers should be armed with one of their Department-approved firearms during any off-duty arrest when acting under the authority of this General Order and Section 790.052, Florida State Statutes.

- Off-duty officers shall not utilize any non-Department-approved firearm to take any law enforcement action authorized in this General Order and Section 790.052, Florida State Statutes unless it is used to prevent injury or death to themselves or another person.

D. Off-duty officers who affect arrests shall summon on-duty officers as soon as practical. Additionally they shall ensure the appropriate arrest/booking paperwork is completed contemporaneous with the arrest.

E. Off-duty officers shall submit other required police reports within twenty-four (24) hours of the arrest, unless directed to do otherwise by an on-duty supervisor.

V. ARRESTS WITHOUT A WARRANT

A. When effecting arrests without a warrant, officers shall comply with Chapter 901, Florida State Statutes, and current federal and Florida case law.

B. Officers shall not enter a dwelling or structure to affect a warrantless misdemeanor arrest, absent a valid exception to the search warrant requirement.

VI. ARRESTS WITH A WARRANT

A. Before effecting an arrest with a warrant, officers shall determine if:

- The person to be arrested is the one for whom the warrant is issued.
- The warrant is valid.

B. Officers shall use reasonable diligence to ensure the person to be arrested is the person named in the warrant. When in doubt, officers shall use simple and direct means of checking identification when such means exist (e.g., photographs, fingerprint classifications, intelligence information).

C. Officers shall verify the existence of all Leon County arrest warrants through the Leon County Criminal Justice Information System (CJIS). CJIS allows twenty-four (24) hour access to warrant information. Officers who have attended CJIS training may check the system directly. Other officers may request a check through a Public Safety Communications Operator.

D. Officers shall verify the validity of non-Leon County arrest warrants through FCIC/NCIC. FCIC/NCIC allows twenty-four (24) hour access to warrant information. Officers who have attended FCIC Limited Access/CJIS Training may check the system directly. Other officers may request a check through a Public Safety Communications Operator.

E. Officers shall verify arrest warrants and pick-up orders for juveniles by contacting the Juvenile Assessment Center (JAC).

F. When effecting arrests with a warrant, officers shall comply with Chapter 901, Florida State Statutes, and current federal and Florida case law.

G. Officers may arrest a person for whom they reasonably believe a warrant is outstanding; however, since Chapter 901, Florida State Statutes, only allows sheriffs and their deputies to execute arrest warrants, officers shall deliver the arrested person to a deputy sheriff for execution of process. Delivery of an arrested person to the Leon County Detention Facility or the Juvenile Assessment Center (JAC) meets the statutory requirement.

VII. ARREST WARRANTS

A. To obtain an adult or juvenile arrest warrant, officers shall:

1. Complete and sign the probable cause form, and complete and sign (or have the victim sign) the warrant affidavit.

2. Ensure both the probable cause form and warrant affidavit are properly notarized.

3. Contact the State Attorney's Office for review of the probable cause.

4. Deliver the approved probable cause form and warrant affidavit to the Leon County Sheriff's Office (LCSO) bailiff assigned to deliver such paperwork to a judge for review.

5. Pick up the signed paperwork from the LCSO bailiff and deliver it to the Clerk's Office to be logged in and entered into CJIS. The County Clerk receives misdemeanor warrants and the Circuit Clerk receives felony warrants.

   - If the warrant is a traffic warrant, officers shall complete a Uniform Traffic Citation for the applicable charge(s) and leave the appropriate copies with the Clerk of the Court.

C. Once an arrest warrant has been obtained, regardless of who is going to serve it, officers shall write the necessary information on the Arrest/Search Warrant Log located in the Criminal Investigation Division.

   - The officer who originated the warrant shall complete a State Attorney arrest packet (file of all pertinent documents for prosecution of a criminal case) and submit it to the Criminal Investigation Division within ten (10) days from the date the warrant is issued.

D. Officers are not responsible for sending arrest warrants to other jurisdictions. The LCSO Warrants Unit will send arrest warrants to Sheriff's Offices in other jurisdictions if there is a known address for the wanted person in the other jurisdiction.

VIII. ARREST OF FOREIGN NATIONALS

In accordance with the guidelines identified in this procedure, officers shall complete a Consular Notification upon the arrest of a "Foreign National". In some instances, this notification shall be mandatory, while in other instances the notification may be at the option of the foreign national.

A. Upon the arrest of a foreign national, the officer shall first determine if the Consular Notification is mandatory or at the option of the foreign national.

B. Officers shall review the Foreign Consular Notification Form (PD 372), which lists the mandatory notification countries and their applicable facsimile telephone numbers.

C. If the foreign national resides in a mandatory notification country, the officer shall advise the foreign national that notification shall be made to their consular officials.

D. If the foreign national resides in a non-mandatory notification country, the officer shall advise the foreign national of the option for Consular Notification.

- Consular officials may assist the foreign national in obtaining legal counsel, may assist in family notifications, and may, otherwise, be able to respond to procedural questions.

E. When appropriate, officers shall complete the Consular Notification Form and forward a facsimile copy to the appropriate Embassy.

F. Officers shall utilize the web site from the United States Department of State to access facsimile numbers for non-mandatory notification countries.

http://www.state.gov/www/global/legal_affairs/ca_notification/ca_prelim.html

G. Officers shall attach the form to their completed police offense or arrest report and note the date and time of the facsimile Consular Notification in the narrative section.

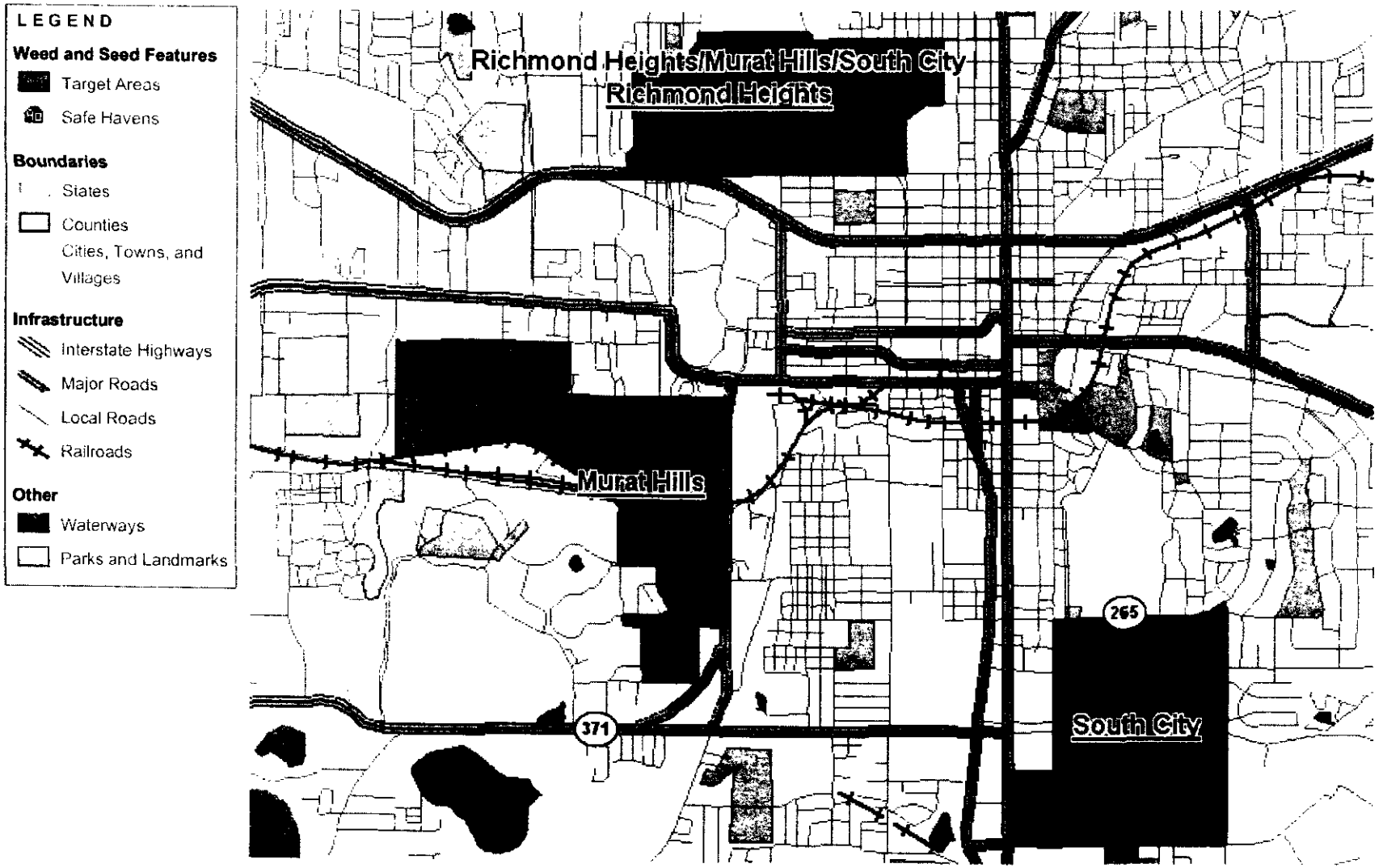
H. Officers shall complete the Consular Notification prior to the end of their tour of duty.

Weed and Seed Data Center

Community Capacity Development Office

(formerly Executive Office for Weed & Seed)

Richmond Heights/Murat Hills/South City (Tallahassee, FL)



Map center (Long, Lat): -84.2957275, 30.4317765 **Map width:** 5.127 mile(s)

Attachment # 1
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